Maternal and Child Health Services
Title V Block Grant

State Narrative for South Carolina

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The signed assurances and certification forms are kept in the official grant file.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

During the past year the MCH block grant process for public comment has been linked to the development of the needs assessment. Focus/workgroups with participants that include agency partners, advocacy groups, regional public health staff, and parent/consumers have been given voice through targeted discussions centered around maternal and child health and children with special health care needs. These discussions defined service barriers and continued fragmentation of care for the children who are most fragile.

Obtaining quality public input during the development of the Title V block grant application during the interim needs assessment years remains a challenge. In the past, several venues for obtaining public input have been explored. Examples include scheduled public hearings, posting on agency website for comment, surveys, executive summaries, etc. These efforts have yielded limited success at best. The most meaningful mechanisms for obtaining public input have come through advisory committees: 1) The Commissioner's Pediatric Advisory Committee- pediatricians and family physicians advising policies impacting health and insurance, and 2) The Commissioner's Obstetric Task Force -- obstetricians, regional public health directors, and regional obstetric support services staff. Each of these committees meets quarterly where members offer timely feedback on policies and practices that must shift in concert with current changing landscape of federal and state dollars.

Following the submission of this year's application and corresponding needs assessment, MCH will take the results back to all stakeholders participating in the process. The 2010 needs assessment and an executive summary of block grant activities will be available via the agency's web-site and directly distributed to key partners. Results and future activities will also be discussed during advisory council meetings and feedback obtained as appropriate.

/2012/ MCH continues to seek input into the application and inform the community about key activities through the Commissioner's OB Task Force and Pediatric Advisory Committee. First Sound, the state's Early Hearing Detection and Intervention (EHDI) program, shares this information and obtains input from their advisory committee. First Sound is also participating in an NICHQ Learning Collaborative this year whose team members include a parent and a pediatric audiologist.

A Perinatal Task Force, comprised of a Neonatalogist and Maternal Fetal Medicine representative from each of the five Regional Perinatal Centers, was convened to provide input related to the Perinatal Regionalization Program and its effects on services provided to the maternal and infant population. Access to care, assurance of services, and policy development were the primary topics of concern.

DHEC is the lead agency for the Personal Responsibility Education Program (PREP) for prevention of teen pregnancy, STI, and HIV. The program is managed through MCH. MCH identified and garnered the support of a group of stakeholders, representative of key agencies in South Carolina, to determine priorities for this funding, including specific curricula, geographic location, and specific high-risk target populations. Agency representation included leadership from SC DHEC, SC Campaign to Prevent Teen Pregnancy (SC Campaign), SC Department of Education (SDE), SC Department of Social Services (DSS), and the SC Department of Alcohol and other Drug Abuse (DAODAS). As a result of several meetings, decisions were made to place emphasis on reaching the highest number of adolescents, as well as focusing on high-risk populations of youth in foster care and/or juvenile justice systems, those receiving substance abuse services, and patients in family planning clinics. Stakeholders also felt it important to maximize funds by utilizing curricula already familiar to the SC Campaign -- who will ultimately be responsible for capacity building efforts - and those supported by SCDE and appropriate to an array of community values in communities across the state.

DHEC is also a key partner with the Evidence Based Home Visitation lead agency, Children's Trust. This partnership facilitates discussion of data and public health impact of home visitation on the findings of the Needs Assessment and Title V activities. //2012//

/2013/ In addition to other public postings, the block grant application will be submitted to Family Connection of SC (Family Voices) for staff review, and for distribution through their on-line mailing list to obtain comments directly from families. This mechanism will be used throughout the year for information and feedback.

Primary partners who continue to consistently comment on the block grant are the OB Task Force, Pediatric Advisory Committee, First Sound Advisory Board, and Family Connection. Our ECCS partnership has connections with a myriad of child-serving agencies and entities across the state and has been an excellent means of obtaining input and aligning priorities. A link to the block grant is posted on the MCH Bureau website.

Over the past year, MCH staff at the State Central Office level conducted site visits to each of the eight DHEC Public Health Regions. These site visits served as a forum to provide region level staff with important MCH updates as well as communicate the direction of the MCH Bureau and Title V services over the course of the next few years. The region staff were presented with a copy of the Block Grant, and feedback, particularly related to the national and state performance measures, was received.//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

The new priorities include:
1. Improve overall pre/inter-conception health status of South Carolina women (Infrastructure Building Service)
2. Reduce the annual rate of maternal deaths (Infrastructure Building Service)
3. Reduce the number of infant deaths due to SIDS/Unsafe sleep environments (Enabling/Population Based Service)
4. Increase the knowledge of appropriate child social-emotional development among parents and early childhood service providers (Enabling Service)
5. Improve systems for obtaining parental involvement in the planning, implementation, and evaluation of DHEC programs and services for CSHCN (Infrastructure Building Service)
6. Promote and support regional based planning of MCH programs/initiatives (Infrastructure Building Service)
7. Increase the degree to which MCH is actively engaged in ongoing assessment and assurance activities (Infrastructure Building Service)
8. Improve coordination of activities related to existing performance MCHB National Performance Measures with a focus on those outside of the MCH Bureau (Infrastructure Building)
9. Invest in building existing MCH workforce leadership competencies and skills related to data analysis and program evaluation (Infrastructure Building Service)

Several of the state priorities for this 5-year Block Grant cycle relate to infrastructure building. In the past year, a survey was conducted in order to assess the effectiveness of the technical assistance that MCH Central Office Program Managers and Coordinators provide to staff at the region level. The survey results have highlighted various areas of success as well as potential areas for improvement. These results will be used to improve technical assistance rendered as well as to inform of deficiencies in staff skills, specifically related to program planning and evaluation.

/2012/The agency has launched a Living Within Our Means initiative. The MCH Bureau has played a large role in this ongoing activity. The primary focus is to ensure the best use of funds toward MCH activities. The 2010 Needs Assessment served as the road map for MCH in this process. The Living Within Our Means process began with an MCH Workgroup gathering for a day long meeting, facilitated by the DHEC Health Services Office of Performance Management, to discuss MCH programs and designate a priority level to each program. The MCH Workgroup consisted of central office MCH staff as well as key MCH staff from each of the 8 health regions. Regional input was extremely important as program prioritization occurred considering limited staff capacity at the local level. Senior management staff met on multiple occasions to discuss regional input and move to next steps of priority setting.

MCH programs were divided into two tiers. Tier 1 programs were deemed critical and therefore

considered mandatory Title V activities. The programs include: Metabolic Screening, First Sound, Preconception Health Coalitions, Regionalization, Postpartum Newborn Home Visits, Oral Health, Careline, FIMR, Surveillance, and School Nurse Consulting. Additionally, in Tier 1, each health region is required to conduct a program activity for each of the identified MCH populations: Reproductive age and pregnant women, Mothers and infants, Children and adolescents, and Children with special health care needs.

Tier 2 programs were considered beneficial to the MCH population if additional funds are available after all Tier 1 programs are fully funded. Some of these programs may be housed in other Bureaus within DHEC that have some MCH population overlap. These programs include: Lead Screening follow-up, Nurse-Family Partnership support, Perinatal STD Surveillance follow-up, Family Planning, Immunizations, TB, Injury Prevention, Sexual Assault, Childhood Obesity Prevention, Postpartum Depression.

Many of the Tier 1 programs are directly related to the new state priorities and improvement of the new state performance measures. The 2010 Needs Assessment was discussed thoroughly at the MCH workgroup meeting to determine how best to operationalize it in the most fiscally efficient manner.

Following the MCH Workgroup meeting, Living Within Our Means work plans were generated with timelines to monitor progress of the Tier 1 programs. In addition to monitoring the Living Within Our Means process, the work plans have been helpful in monitoring progress on Block Grant performance measures and indicators. Central Office staff is still reviewing regional input, and site visits to each health region are being planned.//2012//

/2013/Informally, MCH staff continues to embrace the principles from the Living Within Our Means (LWOM) cultural shift. All vacant positions are reviewed, held for budget considerations, and justified before being filled.

Additionally, there have been various program operation changes since the launch of the LWOM process. Fast Track will be fully deployed statewide by July 1, 2012. Field Delivered Therapy within the Division of STD/HIV is being piloted in 3 regions. There is also a small pilot starting around Family Planning and no show appointing.

Throughout the year, a LWOM action plan was created for three MCH programs: State FIMR program, Post-Partum Newborn Home Visits, and Lead Screening. The action plans monitored progress towards specific goals for each of the programs. For the State FIMR Program, the goal was to implement the state level infant mortality review process. The review team was launched in September 2011. The review team continues to meet bi-monthly and is in the process of developing recommendations for infant death prevention. Currently, case review is limited to deaths occurring in the Regional Perinatal Centers (Level III hospitals), deaths due to unsafe sleep environments, and SIDS.

As a result of the LWOM process, MCH finalized priorities for Postpartum Newborn Home Visits (PPNBHV). At a minimum, Public Health Regions must offer PPNBHVs and NICU Pre-Discharge Visits to all mothers and infants meeting any of the following criteria: (1)Mothers 17 years of age or younger; (2)Infants weighing less than 2,500 grams (<5 pounds, 5 ounces) at birth and infants born prematurely (born at 37 weeks gestation or earlier); (3)All new mothers or infants, who do not fall into the categories above, but who are determined to be high-risk based on the assessment of a public health nurse, a health care professional at the hospital involved in the care of the mother or infant (e.g. a mother with a history of mental illness or a newborn with feeding problems); (4)As a best practice component of the Nurse-Family Partnership (NFP), mothers and infants enrolled in NFP, billable to Medicaid or not. The PPNBHV policy allows for visits to be offered to both Medicaid and non-Medicaid patients who meet the criteria noted above for whom a referral is received. In the coming year, the impact of the revised criteria will be evaluated.

The LWOM process evoked a perceived need to move follow-up of elevated lead levels from the region to the central office level. After evaluating the proposed pilot, it was determined that the regions had both the capacity and the desire to continue local follow-up. They had developed long-standing relationships with the pediatric provider community that they desired to maintain. The State Childhood Lead Screening Coordinator remains available for consultation, training, and physician liaison. She also develops, updates, and distributes agency materials focused upon lead screening.

Under LWOM, Newborn Metabolic Screening, First Sound Newborn Hearing Screening, and the Care Line continue to function with no major changes in their operating procedures.

To insure that the 5-year Needs Assessment and the Living Within Our Means work plans were being operationalized appropriately, key MCH Central Office Staff conducted site visits to each of the eight public health regions. Staff conducting the visits included the Women and Children's Services Division Director, the MCH Epidemiologist, and the MCH Planning and Evaluation Coordinator. These site visits were an opportunity to provide the region staff with important information related to data, budgets, and programs.

The site visits were well-received by the region staff and created an opportunity for open and honest conversation about program operations, staff capacity, and barriers to health indicator improvement and successful program implementation. The data shared at the site visits was centered around the Title V national and state performance measures. During the site visit, region staff was given the opportunity to share special initiatives being implemented in their respective regions. Many of these initiatives will have a positive impact on a variety of MCH health indicators. Following the site visit, region staff demonstrated a better understanding of Title V and the role they play in reporting and performance measure improvement. MCH Division Directors will review the draft plans and provide program guidance for implementation.

Title V priorities, state and national performance measures were driving forces in the LWOM discussion. Participants recognized the importance of assuring decision-making included these parameters. Although CSHCN was not formally included in the LWOM process, a budget analyst worked with the CSHCN Division Director to monitor expenses to increase efficiencies.//2013//

III. State Overview

A. Overview

General Demographic Overview

Approximately 68% of the State is White, 28.5% African American, and 4.1% of Hispanic ethnicity. Nearly one quarter (23.8%) of the State's population is under the age of 18. South Carolina has a large rural contingency with 70% of the State residing in urban commuting areas, 20% in large rural areas, and 10% residing in small rural areas. As typical of the Southeastern United States, African Americans are disproportionately represented in small rural areas of the state placing them in a doubly disadvantaged position, and adding to the unique challenges for delivery of Title V services.

/2012/ Data reflects only a slight change in demographics in South Carolina. In 2009, 69.4% of the state was Caucasian, 28.6% African American, and 4.5% of Hispanic ethnicity. //2012//

/2013/ The population demographics with respect to race in South Carolina in 2010 were nearly identical to those in 2009. In 2010, 69.2% of the population was White and 28.7 was African American. South Carolina did see a larger change in ethnicity, as 5.1% of the population was Hispanic in 2010. Estimates of the percentage of population living in urban and rural communities have not changed from those reported above. //2013//

Overall Health and Well Being

Pregnant Women, Mothers, and Infants - Improved birth outcomes remain a priority for South Carolina. The State has seen notable improvements in infant mortality rates over the past few years, particularly among African American infants. The 2008 infant mortality rate of 8.0 per 1,000 live births is among the lowest rate in 20 years. Moreover, the infant mortality rate among African American infants (11.4) has declined for 3 consecutive years and is the also at an all time low. Reductions in the proportion of very low birth weight outcomes among African American infants are a significant factor in the observed decrease in infant mortality rates. Although progress is being made, increasing obesity and chronic co-morbidities including hypertensive disorders and diabetes continue to adversely impact pregnancy outcomes. Deaths due to accidents, particularly accidental suffocation and co-sleeping, remain a significant issue impacting the health and well being of infants.

/2012/ South Carolina continues to make improvements in infant mortality. The 2009 infant mortality rate declined significantly to 7.1 per 1,000 live births from 8.0 per 1,000 live births in 2008. The African American infant mortality rate continues to decline (10.5); however, the disparity between the African American and Caucasian infant mortality rates remains constant. The decline in infant mortality rate for 2009 was partially attributable to the significant decline in sleep-related infant deaths (i.e. SIDS and accidental suffocation in bed). //2012//

/2013/ The 2010 South Carolina infant mortality rate increased slightly, going from 7.1 infant deaths per 1,000 live births in 2009 to 7.4 in 2010. The overall increase was due entirely to a 7% increase in the neonatal mortality rate from 2009 to 2010. An increase in deaths due to SIDS and accidental suffocation and strangulation in bed was observed from 2009 to 2010, following a substantial decrease in these deaths from 2008 to 2009.

Many strategies to improve neonatal infant mortality include efforts to improve preconception and perinatal health behaviors. Some of these heath behaviors have improved in South Carolina from 2008 to 2010 including: having intended pregnancies (51.7% to 58.8%), having adequate or adequate plus prenatal care (69.2% to 75.9%), and back infant sleep positioning (62.3% to 68.8%). However, other behaviors or risk factors have remained constant or worsened, including: prenatal or multivitamin use (40.6% to

40.8%), pre-pregnancy obesity (27.8% to 30.6%), and smoking before pregnancy (26.5% to 29.0%). Prematurity prevention continues to be a primary focus for the MCH Bureau in its ongoing efforts to reduce infant mortality.//2013//

Children - Approximately one in five children and adolescents under the age of 19 live in homes currently under the federal poverty line, with values ranging from 14%-50% by county. The general health status of South Carolina children seems to be consistent with the rest of the United States. According to 2007 National Survey of Children's Health (NSCH) data, 84.5% of parents report their children's health as excellent to very good; which is comparable to 84.4% among the nation. Also consistent with national data, approximately 9.8% of South Carolina children lack health insurance and 15.4% lacked consistent coverage during the year. Moreover, nearly one in every ten (9.7%) children have injuries that require medical attention and one of every four (26.5%) children between 4 months and five years are determined to be at moderate to high risk of developmental or behavioral problems. However, a much higher proportion of South Carolina children between 6-17 repeat a grade in school compared to the rest of the country (16.0% versus 10.6%).

CSHCN - Like all children that meet the AAP/MCHB definition of "children with special health care needs", many children in SC with chronic illnesses or disabling conditions have difficulty affording out-of-pocket expenses required to meet their child's health care needs. According to the 2007 National Survey of Children with Special Health Care Needs, 15.2% of South Carolina children (157,801) have special needs, compared to 13.9% among the nation. For the most part, key indicators for CSHCN in South Carolina are consistent with what is observed at the national level. Approximately 60% of South Carolina families partner in decision making at all levels and are satisfied with services received compared to 57.4% among the nation. The proportion of South Carolina parents reporting receiving comprehensive, ongoing, coordinated care in a medical home (53.1%) is slightly higher than 47.1% of parents across the country. The proportion of South Carolina parents reporting adequate public or private insurance to pay for needed health services (61.1%) is comparable to 62.0% of parents across the country.

Health Care Environment

The passage of health care reform during the previous fiscal year will have a significant impact on current and future Title V programs and activities. The impact and ramifications of health care reform can vary by program and population; however, as access to health insurance (particularly for CSHCN) increases, the role of public health and Title V will need to be examined to best align services with needs. DHEC Health Services created a policy review team to examine the details and assess potential implications for public health services. MCH has three representatives on this committee.

The current state health care environment presents significant challenges and opportunities. The unemployment rate in South Carolina has reached 12.6% creating a significant increase in the need for health services. The downturn in the national/state economy continues to create state fiscal challenges that translate to significant budget cut. Declining state revenue coupled with an increased need for basic health services has challenged the healthcare environment.

As a primary source of insurance for women and children in SC, Medicaid policy is central to discussion of the state health care environment. Over the past year, Medicaid eligibility has seen significant expansion, with the largest increases among children. As the driving force in shaping this health care environment, Title V programs and activities are inseparably linked and must adjust along with Medicaid policies.

/2012/ Expansion of Medicaid eligibility has increased the number of children served with Medicaid funds; however, due to budget reductions, both obstetric and pediatric providers face fee reimbursement reductions. At this time, it is unclear how this will affect access to care for the

MCH population in the State. Conversation related to such implications remains at the forefront of the Commissioner's Obstetric Task Force and the Commissioner's Pediatric Advisory Committee. The meetings for these groups serve as a forum for obstetric and pediatric providers, Medicaid policy makers, and MCH staff to discuss such issues. The DHEC Commissioner serves on the SC DHHS Medical Care Advisory Committee, which is being revamped under the leadership of the new SC DHHS agency director. //2012//

/2013/ SC DHHS will be implementing new provider enrollment and screening regulations published by the Centers for Medicare and Medicaid Services (CMS) under standards established by the Affordable Care Act. The regulations are expected to be implemented effective August 1, 2012. It appears at this time they will require a separate NPI number for each employee providing a Medicaid-reimbursed service in contrast to the current ability to utilize an agency NPI number. SC DHHS held a preliminary meeting for affected state agencies to discuss the new requirements, and then decided due to the many complexities involved in each agency it would be beneficial to hold individual meetings. It is uncertain at this time what impact this change may have upon the ability of paraprofessionals to bill for services.//2013//

Pregnant Women, Mothers, and Infants

Approximately half of all pregnancies among South Carolina women remain unplanned. South Carolina is fortunate to have the Medicaid Family Planning waiver; however many challenges to accessing contraceptive services remain due to barriers stemming from CMS and the Federal Deficit Reduction Act. Rising costs for contraceptives, particularly long-term methods, is an ongoing issue. The penetration of Medicaid Managed Care has also created challenges in accessing care for pregnant women. Clients are automatically enrolled into one of several managed care plans, each unique in what they provide, thus, fragmenting consistency of covered services.

/2013/ The Birth Outcomes Initiative (BOI) has greatly expanded during the past year. This group was convened by SC DHHS. Key participants include DHEC, March of Dimes, SC Hospital Association, Office of Research and Statistics, USC School of Medicine, Healthy Start, SC First Steps, private OB practitioners, PASOS, and numerous other stakeholders. At its inception in July 2011, the group's chief goal was to improve the health of newborns in the Medicaid program. The BOI's scope has broadened to include private payers and now focuses on the health of all mothers and their newborns. Numerous policy and systems changes have been initiated and/or implemented through the work of this group, including the four following areas.

First, 43 hospitals that deliver babies in South Carolina have signed a pledge to end the practice of non-medically indicated inductions prior to 39 weeks for pregnant Medicaid enrollees, which are harmful to the growth and development of neonates.

Second, pregnant women applying for Medicaid under Optional Coverage for Pregnant Women and Infants (OCWI) may enter the program under assumptive eligibility provisions. If a woman declares that she is pregnant, and submits an application, she can be determined Medicaid eligible based on her attestation of income, resources, and citizenship for a 30-day period, while she is given the opportunity to return the necessary verification to determine continued eligibility.
Third, SC DHHS will create and implement an automated process to enable providers to assist with applications. This process should roll out before the end of 2012.
Fourth, effective March 1, 2012, Medicaid will reimburse hospitals for insertion of of long-acting reversible contraceptives following delivery. Some physicians are reluctant to insert IUD's following delivery but most would be comfortable with contraceptive implants. Since a large percentage of women are not having postpartum checkups, this could help reduce unintended pregnancies/short interconception periods since there will be ready

access to a method. The low rate of completion of the checkups will be a focus for improvement in the coming year.
Fifth, SC DHHS launched the Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative in August 2011. This initiative was implemented in an effort to improve birth outcomes by addressing various maternal health risk factors such as alcohol or other substance abuse, depression, smoking, and domestic violence. Medicaid providers are now able to bill separately for screening and brief intervention services rendered with the SBIRT initiative, in addition to billing for routine office visits for pregnant women as well as women within 12-months postpartum.
Since its inception, MCH and other agency staff contribute to the work of each of the BOI's workgroups: Vision Team, Behavioral Health, Care Coordination, Health Disparities, and Patient Safety. A Breastfeeding workgroup was added in June 2012, and is led by DHEC and MCH staff.//2013//

/2013/ SC DHEC was privileged to participate in the Regions IV and VI Infant Mortality Summit held in New Orleans in January 2012. Team members were Dr. Lisa Waddell, DHEC Deputy Commissioner for Health Services, Lucy Gibson, Director, DHEC Division of Women and Children's Services (attending for MCH Bureau Director Brenda Martin), Michael Smith, MCH Epidemiologist, Mark Jordan, DHEC Office of Primary Care, Dr. Rick Foster from the SC Hospital Association, Valeria Williams from SC DHHS, and Megan Branham from the March of Dimes. The group benefited greatly from the facilitated workgroup sessions to initiate the State Infant Mortality Reduction Plan.

The plan, now titled "Healthy Mothers, Healthy Babies: SC's Infant Mortality Reduction Plan", includes SMART Objectives with timelines and lead staff assigned for each of 8 strategic priorities: (1)Develop and Implement a Birth Outcomes Improvement Plan that Adopts a Life Course Perspective, (2)Implement Health Promotion and Education, (3)Ensure Quality of Care for All Women and Infants, (4)Enhance Service Integration for Women and Infants, (5)Improve Maternal Risk Screening for All Pregnant Women, (6)Improve Access to Health Care for Women Before, During, and After Pregnancy, (7)Use Data to Understand and Inform Birth Outcomes Improvement Efforts and (8)Eliminate Health Disparities and Promote Health Equity. We will use this working document to monitor progress. Other activities and objectives will be added as indicated. Numerous community partners are involved in working toward these objectives. This plan is a perfect complement to the work begun by the Birth Outcomes Initiative, serving as the strategic plan for improved birth outcomes and will be presented for adoption by the BOI Vision Team once complete.

In early June 2012, Dr. Michael Lu expressed the desire for states to learn from each other and announced the development of the Collaborative Improvement and Innovative Network (COIN). Five strategic teams make up the collaborative, and the group will meet in July 2012.

During the past year MCH instituted priorities for the provision of Postpartum Newborn Home Visits (PPNBHV) in response to further staff reductions. DHEC Public Health Regions must offer PPNBHVs and NICU Pre-Discharge Home Visits to all mothers and infants meeting any of the following criteria: Mothers 17 years of age or younger, infants weighing less than 2,500 grams (< 5 pounds, 5 ounces) at birth, and infants born prematurely (born at 37 weeks gestation or earlier. Services must also be offered to all new mothers or infants, who do not fall into the categories above, but who are enrolled in Nurse Family Partnership (NFP) or are determined to be high-risk based on the assessment of a public health nurse, a health care professional at the hospital involved in the care of the mother or infant (e.g., nurse, social worker, registered dietician, lactation consultant), or a physician involved in the care of the mother or infant. (Examples may include a mother with a history of mental illness or a newborn with feeding problems.) In addition, these visits are provided for mothers and infants enrolled in NFP as a value-

added service. The DHEC NFP nurse provides the visit since she has an established relationship with the mother. Many of the DHEC NFP nurses were already certified to perform PPNBHVs, but a training course is available for those needed to acquire these skills. Visits must be offered to both Medicaid and non-Medicaid patients who meet the criteria noted above for whom a referral is received. Other visits may be made if the regions have the local capacity to do so.//2013//

/2012/ Effective January 1, 2011, SC DHHS was approved to institute a State Plan Amendment (SPA) for Family Planning Services that has taken the place of the Family Planning Waiver, which has been in place in SC for more than 15 years. In addition to female clients, males are now eligible to apply for SPA to receive family planning services and treatment for specified STD's identified as a result of the family planning exam. DHEC's FP Program is working to increase knowledge of and access to these expanded services. There is a 3-month retroactive coverage period, and there is no age limitation, which makes this program available for more teens. DHEC and SC DHHS have worked closely to make sure this transition was as smooth as possible and to ensure all health department clients are given an opportunity to apply. //2012//

SC legislation requires health care providers to report to law enforcement any children under age 16 that admit having sexual relations. Teens seeking family planning services as well as some young prenatal women may have been adversely impacted. The Office of General Counsel and MCH have provided extensive training and resources to ensure staff report in accordance with the law. In addition, the program has developed talking points to assure staff give a consistent message, comprehendible by teens seeking care. Simultaneously, they are working with advocacy agencies to promote legislation that will allow medical providers exemption from reports that are solely based upon age.

/2012/ The Family Planning Program is conducting a "Mystery Shopper" assessment to evaluate the possible impact of this reporting law on access to services. //2012//

/2013/ The Mystery Shopper assessment was conducted in 2011 and indicated that teens were having trouble accessing the clinical system. Based on the barriers identified, quality improvement efforts are underway. As a result of the Mystery Shopper assessment, special Open Access appointment slots (same day and up to 36 hours from time of the call) have been established, a statewide Teen Friendly Clinic training was conducted, and teen friendly waiting rooms are being developed in certain clinics. There are also regional teen grants in place to provide services to teens in different areas of the state. The teen caseload for FY 2011 was 16,071 compared to 18,687 in FY 2010. Although the number has decreased as a result of staff reductions, the quality improvement measures in place will help maintain the teen caseload as much as possible through word of mouth marketing among teens. It is still unclear if the reporting law has had a negative effect on the family planning teen caseload. //2013//

South Carolina continues to see reductions in the availability of obstetric care in areas of the state with vulnerable populations. In the past year, Allendale Hospital, a rural facility in an underserved area, discontinued obstetric services. In addition, North Central (FQHC) in York County stopped providing prenatal care services. The clinic saw an average of 900 patients annually, many of which were of Hispanic ethnicity. After extensive community advocacy, the clinic re-opened but with limited staffing. These examples illustrate how loss of care in an already underserved area creates significant barriers in obtaining needed prenatal services.

/2012/ North Central (FQHC) in York County has resumed a minimal level of prenatal care direct services, employing one Certified Nurse Midwife and consultation of an OBGYN. These services are funded through self-pay clients and Medicaid reimbursement.

Effective January 1, 2011, SC DHHS was approved to institute a State Plan Amendment (SPA) for Family Planning Services that has taken the place of the Family Planning Waiver, which has

been provided for more than 15 years. In addition to female clients, males are now eligible to apply for SPA to receive family planning services and treatment for specified STD's identified as a result of the family planning exam. Both male and female income eligibility for SPA is 185% of the federal poverty level. DHEC's FP Program is working to increase knowledge of and access to these expanded services. There is a 3-month retroactive coverage period, and no parental consent for application is required, which makes this program accessible to more teens. DHEC and SC DHHS have worked closely to make sure this transition was as smooth as possible and to ensure all health department clients are given an opportunity to apply. //2012//

Children

As noted, Medicaid eligibility expansion among children has been substantial. With growing numbers of families seeking Medicaid coverage for their children, revenue to support Medicaid services remains an issue. Efforts to enroll children into MCO's to improve quality and reduce cost have left many families continuing to struggle with the enrollment process, expectations of the medical homes, and understanding of the systems of care. Lack of access to behavioral health and subspecialty medical providers remains an area of concern. SC DHHS is instituting a payment system for credentialed private behavioral health providers in the summer of 2010 to address these needs. MCH provides few direct services for children; however, shaping policy related to children's services is an ongoing MCH leadership role.

/2012/ The demand for Medicaid continues to grow while the state funds available to support the program are diminishing. Based on discussions with the SC AAP and at the Commissioner's Pediatric Advisory Committee, there is concern that a recent 3% rate cut for all Medicaid providers will result in providers' either limiting or discontinuing services to Medicaid patients. This could also result in increased emergency room visits for non-emergent conditions.

/2013/ SC DHHS estimates that about 60,000 children are eligible for Medicaid that are not currently enrolled. SC DHHS is working diligently to enroll as many as possible prior to the planned full implementation of the Affordable Care Act. This very positive step will improve access to care but may temporarily strain the service delivery system if an adequate number of providers are not available to respond to the swelling demand for services.

Effective July 1, 2012, SC DHHS is updating the periodicity schedule for EPSDT services to include eight (8) additional preventive visits for recipients less than 21 years of age. This policy change will be applicable to all Medicaid providers, including fee-for-service, Medical Home Networks, and Managed Care Organizations. This increase in the number of preventive visits allowed can have a positive impact the health of South Carolina's children because it provides more opportunities for early identification of acute or chronic health issues. //2013//

As of July 1, 2011, the SC Immunization Program is being revised. The former Vaccine Assurance For All Children (VAFAC) providers are being required to re-enroll as Vaccine For Children (VFC) providers. Updated guidelines and accountability measures are now in place to assure that federally funded VFC vaccines are provided only to the VFC eligible population. Also starting July 1, 2011, the SC Immunization Program will have a parallel program to VFC, called the SC STATE Vaccine Program. This program will allow enrolled providers to serve state and federal 317 funded vaccines to VFC-eligible underinsured children and a limited group of insured children with financial hardship. The SC STATE Vaccine Program was designed to allow VFC-eligible underinsured children to continue to be served in their medical home instead of having to be referred to a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or DHEC health department to receive VFC vaccines. The insured population with financial hardship is limited to children with an insurance deductible of = $2000 which has not been met and paying for the cost of private stock vaccine would be a financial burden for the family. Human Papilloma Virus (HPV) vaccine and Meningococcal conjugate vaccine (MCV4) are not currently provided by

the SC STATE Vaccine Program. The current guidelines for the SC STATE Vaccine Program are in effect for a transition period from July 1, 2011 through September 30, 2011. Guidelines beginning October 1, 2011 will be determined by the newly developed SC Immunization Advisory Group, convened by DHEC, and will depend on available state and federal 317 funding.

/2013/ The VFC program and a parallel STATE Vaccine Program were implemented statewide on July 1, 2012. These programs included increased requirements for vaccine accountability as of July 1, 2012. An online system called the South Carolina Immunization Provider Access System (SCI PAS) was implemented on June 15, 2012 for enrollment and re-enrollment in the VFC program. In July 2011, the Immunization Division exhibited at the Annual Conference of the SC AAP on the immunization registry and proposed immunization registry regulation. Work continued throughout this time period to gain immunization stakeholder support and to write the proposed regulation for the mandatory statewide immunization registry. The DHEC Board approved the proposed immunization registry regulation on June 14, 2012 for it to move forward to the SC Legislature for consideration. The reporting of immunization data via HL7 electronic data transfer increased significantly during this time period. As of March 2011, 4 providers were submitting immunization data to the registry via HL7. As of June 14, 2012, 63 providers were submitting immunization data via HL7.

A school entry requirement for pertussis vaccine (Tdap) for seventh graders effective August 2013 was announced to immunization providers and schools in March 2012. //2013//

DHEC is serving as the lead agency for Personal Responsibility Education Program (PREP) funding from the Administration for Children and Families (ACF). These funds must be used for evidence-based programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), including HIV/AIDS. In addition, instruction must be provided on at least three of six adulthood preparation subjects. The three evidence-based programs chosen for implementation in SC are "Making Proud Choices! A Safer Sex Approach to STDs, Teen Pregnancy, and HIV Prevention" for young adolescents(11-13), "Safer Choices", a two-year, school-based HIV, other STD and pregnancy prevention program for high school students, and "What Could You Do?", an interactive video intervention aimed at increasing young women's (14-18) ability to make less risky sexual health decisions. DHEC has contracted with the SC Campaign to Prevent Teen Pregnancy to conduct the RFP process necessary to award mini-grants. The availability of funding was widely publicized and a bidder's meeting was held to assist potential applicants with the process. Twenty-four completed grant applications were accepted for review on May 19. Awards will be made effective July 1, 2011. //2012//

CSHCN

Medicaid policies are also instrumental in shaping program activities for CSHCN. Navigation of multiple health care systems has become increasingly difficult with expansion of managed care organizations. Although there are some core expectations of all MCO's, there is great variability in their individual policies and procedures pertaining to eligibility and prior approval for services. Pediatric sub specialists affiliated with the four hospitals in the SC Children's Hospital Collaborative serve as a network of providers available to CSHCN throughout the state. These providers, in addition to pediatric and/or family practices with effective medical homes, help assure availability of high quality services for all CSHCN in the state. However, financial and geographic accessibility remain an issue for families throughout this poor, rural state.

DHEC remains a major funding source for medical and related services for CSHCN with a range of medical conditions through the Children's Rehabilitative Services (CRS) program. Services are provided by approved physicians, pharmacies, and DME suppliers. Covered medical services are most frequently provided through the state's four children's hospitals and/or providers affiliated

with these hospitals.

In January of 2010, the Governor transferred lead agency status for Idea Part C (BabyNet) from DHEC to South Carolina First Steps. DHEC remains under contract with First Steps to provide a set array of services; however, we are no longer responsible for the oversight and implementation of services to those from birth to 3 with developmental disabilities. Key MCH staff members devoted many hours of detailed work to assure a smooth transition of lead agency responsibilities. Remaining programs have shifted focus to provision of service coordination within a broader system of care. The need to maximize limited resources for the largest number for children continues to be a priority.

/2012/ All remaining IDEA Part C early intervention program (BabyNet) activities will be transferred from DHEC to SC First Steps to School Readiness, which is part of the SC Department of Education, effective July 1, 2011. The transfer of both the BabyNet program and staff will create an opportunity for reassessment of roles and responsibilities within the Division of CSHCN, which will be completed in the upcoming year. //2012//

Agency Priorities and Title V

Agency priorities impacting Title V programming are reflected in the 2005-2010 DHEC Strategic Plan. Goal 2-C of the plan is to 'Improve Maternal and Child Health.' Within this goal several agency priorities are noted and include: newborn metabolic and hearing screening and follow up, postpartum newborn home visit, reproductive health services, review of infant and unexplained child deaths, WIC caseload, and breastfeeding. Under Goal 2-E 'Access to Comprehensive, Quality Care,' creating medical home partnerships (for all populations) are notable priorities.

The MCH Bureau and Title V are tasked with implementing programs and activities around these priority areas. With many competing demands, prioritization of programs and initiatives is critical. Decreasing state capacity resulting from ongoing fiscal challenges must shape the current focus of Title V. In addition to existing Title V outcome and performance measures, Title V resources continue to be devoted to carrying out activities related to agency priorities.

The priority for Title V dollars is advancing focus toward core public health functions of assessment, policy development, and assurance. As state personnel capacity continues to decrease, it is necessary to invest in workforce development to assure remaining public health workers have the knowledge, skills, and abilities to perform these core public health functions and essential services.

/2012/ Infant Mortality is the critical focus of the MCH Bureau. Efforts throughout all programs can be linked to the variables impacting pregnancy outcomes. //2012//

/2013/ South Carolina's infant mortality rate increased slightly from 7.1 infant deaths per 1,000 live births in 2009 to 7.4 in 2010. The rate remains one of the lowest infant mortality rates ever recorded in South Carolina. Though the overall infant mortality rate increased, the disparity in infant mortality between white and minority women decreased from 2009 to 2010 and is below the average US infant mortality racial disparity. However, minority infants still die at nearly twice the rate at which white infants die in South Carolina. The MCH Bureau is committed to reducing the overall burden of infant mortality on South Carolinians as well as reducing the racial disparity. To this end, DHEC is a key partner in the South Carolina Birth Outcomes Initiative (BOI) along with the Department of Health and Human Services, the South Carolina Chapter of the March of Dimes, and the South Carolina Hospital Association. The BOI is a coalition with five workgroups (Patient Safety, Health Disparities, Comprehensive Behavioral Health, Care Coordination, and Data) with a goal to reduce the prevalence of low birth weight births, a leading cause of infant mortality in South Carolina. Achievements of the BOI over the past year include receiving pledges from all of the state's birthing hospitals to stop the practice of inducing labor or delivering

infants via cesarean section prior to 39 weeks gestation without a medical indication; developing a Screening, Brief Intervention, Referral, and Treatment (SBIRT) program to screen pregnant women for substance use, depression, and domestic violence and refer them to appropriate care; and developing a comprehensive analysis of the risk factors for low birth weight births and ongoing programs that can reduce the prevalence of these births as well as the racial disparities in the rate of low birth weight births. DHEC staff are represented on each group, providing a public health perspective to the discussion. In all internal program areas, discussions occur regarding cross fertilization of program initiatives as well as specific activities that can impact perinatal outcomes (e.g. oral health and periodontal disease). //2013//

Notable Accomplishments

Despite significant challenges, strides have been made to improve the health and well being of mothers and children in the State.

Pregnant Women, Mothers, and Infants

The March of Dimes recognized the agency with its National Award for Excellence in Newborn Screening for the comprehensiveness of the screening panel. A collaborative effort with the Deputy Commissioner for Health Services, the Bureau of Laboratories, and the agency's legislative liaisons, the Newborn Metabolic Screening Program successfully secured an increase laboratory fee for the initial specimen submitted for each infant from $42 to $68.51.

MCH staff and partners from the SC Department of Education and SC Campaign to Prevent Teen Pregnancy were one of 5 states awarded AMCHP Adolescent Preconception Health Action Learning Collaborative. The team is receiving training, technical assistance, and a $2500 stipend to implement their project.

/2012/ The AMCHP Adolescent Preconception Health Action Learning Collaborative has ended. The MCH Bureau and partner organizations collaborated to heighten preconception health awareness among the 18-20 year old population by offering general health information via an innovative, comprehensive reproductive health website, CarolinaTeenHealth.org. The website launched January 4, 2011 and is accessible to teens throughout the state. The site has been marketed to teens via billboards, smart phone applications, and promotional wallet cards. MCH Bureau staff have presented the results of the grant project at the 2011 AMCHP Conference and the 3rd Annual Summit on Preconception Health and Health Care. Staff will also present results at the upcoming APHA Conference. //2012//

Nurse-Family Partnership (NFP) has been newly implemented in SC. The evidence-based home visitation program aims to improve the health, well-being and self-sufficiency of low-income, first-time parents and their children. NFP is serving up to 100 mothers and babies in each of the 6 service hubs: Anderson, Berkeley, Charleston, Dorchester, Greenville, Horry, Lexington, Richland, and Spartanburg Counties.

/2012/ The MCH Bureau is working with Children's Trust staff on the use of ACA funds for the expansion of NFP across the state. Children's Trust is the designated lead agency for the SC Maternal, Infant, and Early Childhood Visiting funding. //2012//

Under the Birth Defects Prevention Act, the Birth Defects program designating the Greenwood Genetic Center to act on behalf of the program for Neural Tube Defect (NTD) prevention efforts. The Birth Defects Program shares surveillance data and supports GGC efforts to assure any women with a diagnosed NTD are referred to a prevention program that provides free folic acid and counseling.

Caring for Tomorrow's Children (CFTC) celebrated its 20th year of supporting mothers to be in

2009. This resource guide, a partnership effort between Title V, Blue Cross/Blue Shield of SC, and the Office of the Governor, emphasizes the importance of preconception health, prenatal care, signs and symptoms of preterm labor, postnatal care, well-child care, SIDS, and immunizations. It is available free of charge to every pregnant woman in SC.

The Division of Oral Health released state recommendations on Oral Health Care for Pregnant Women."

/2012/ The Division of Oral Health distributed postcards announcing the web-based resources for recommendations. In addition, referral forms were sent to 260 obstetricians, family practitioners and midwives across the state. Presentations regarding the state recommendations on Oral Health Care for Pregnant Women were conducted for the SC Primary Health Care Association's Clinical Practice Networking Meeting, SC DHEC Commissioner's Obstetric Task Force, Health Start Regional Health Directors and the SC Dental Hygiene Association. //2012//

/2013/ The Head Start Dental Home Initiative project was used to create a resource for Head Start staff and parents and to further refine the resources and adapt them for use in the clinical setting. Clinicians involved in the Q-TIP project (DHHS CHIPRA Grant) focusing on oral health integration have begun to utilize oral health materials for mothers, infants and pregnant women This has resulted in a more effective way to reach infants with an oral health message during the well visits that occur prior to the age one dental visit. //2013//

The Fetal and Infant (FIMR) program has collaborated with the Emergency Medical Services for Children program to carry out legislative mandates for shaken baby syndrome education. This partnership includes purchase of educational materials including a doll made to simulate the results of harsh shaking on a small child that is used in training sessions. In 2010, the FIMR program also collaborated with the state level Safe Kids agency to expand the Cribs for Kids Program statewide. The program provides a crib for infants of low- income parents and provides them with education on safe sleep positions and proper crib environments.

/2012/ The MCH Bureau continues to collaborate with the state Safe Kids agency for statewide expansion of the Cribs for Kids program. A uniform training curriculum and tracking database is being developed so that local Cribs for Kids programs will have data that can be compared to other local programs. //2012//

/2013/ The FIMR program partnered with the Emergency Medical Services for Children (EMSC) program in an effort to provide more safe sleep training tools for providers. The training tools were originally purchased in 2009 with March of Dimes grant funds, but as the supply exhausted, the EMSC program provided the necessary funds to ensure that infant health education providers had the appropriate tools to educate parents and caregivers on the dangers of unsafe sleeping environments. //2013//

/2012/ The infant mortality rate for SC continues to decline. MCH programs and services continue to impact the health and lives of women and children throughout the state. Strong partnerships with First Steps, Children's Trust, and the March of Dimes have aided in the reduction of the infant mortality rate and birth outcome disparities.

The MCH Bureau was also awarded a grant from ASTHO to implement a Folic Acid and Preconception Health Campaign for adolescents utilizing social media. The MCH Bureau has enlisted the assistance of a diverse Student Advisory Board, comprised of college students from around the state, to develop the preconception health message and disseminate the information. Work on this grant will continue throughout the year. //2012//

/2013/ Jane Key, State Women's Health Coordinator, presented the session "Minority Communities and Preconception Health" at the American Public Health Association's

139th Annual Meeting and Exposition in Washington, DC.//2013//

/2013/ Kathy Tomashitis, the Newborn Metabolic Screening Program Manager, has been asked to participate in the Newborn Screening Laboratories and Programs Workgroup of the Newborn Screening Translational Research Network (NBSTRN). The main goal of this group is to develop an infrastructure and informatics system that includes registries, databases and other necessary newborn screening research resources. //2013//

/2013/ Tara Carroll was elected as a Member at Large for Directors of Speech and Hearing Programs in State Health and Welfare Agencies (DSHPSHWA).//2013//

/2013/ One of the parents on the NICHQ Team who was instrumental in getting the SC Hands & Voices Chapter started met with Governor Nikki Haley to discuss the issue of mandatory insurance coverage for hearing aids. There is a bill concerning this issue in process in the Senate and House.//2013//

Children

SC ECCS is working with Greenville County partners and the Connecticut Help Me Grow (HMG) Replication Team to establish the HMG combination of five interrelated components that work collaboratively. These components ensure child health providers are trained in effective developmental surveillance and screening, offer a free and confidential telephone access point that links children and families to existing services, maintain an inventory of community-based programs, and maximize use of resources available to those who contact the call center.

/2013/ The SC Help Me Grow (HMG) replication project has a tentative start date in August 2012 for the telephone access of resources in Greenville County. The development of the Help Me Grow call center is housed within the Child Advocacy Division of the Greenville Children's Hospital. The HMG National team is working on a database for new states to use for data collection and Greenville will be one of the test sites for this program. As of June 2012, Help Me Grow has interviewed candidates for the HMG call center and several candidates were selected for second interviews. Also underway is the development of the HMG Advisory Team.//2013//

The Division of Oral Health created web based resources for women and medical/dental providers. "South Carolina Takes Action: Oral Health for the Young Child," is currently being used for the development of toolkits for clinicians and Early Head Start parent educators funded by the Academy of Pediatric Dentistry. In addition, a DOH representative was appointed to the Department of Education's Committee charged with revising the Health and Safety Standards. As a result, oral health was included within objectives across grade levels. SC is one of the few states to have oral health directly referenced within their Health and Safety Standards.

MCH staff provided technical assistance to plan and implement the 2010 SC Community Access to Child Health (CATCH) Meeting .The 27 practices represented at CATCH completed a survey from the Division of Oral Health (DOH), with seven practices indicating they currently apply fluoride varnish. Seventeen practices volunteered to focus test an Early Childhood Oral Health Toolkit for providers, other opportunities for further collaboration between SC AAP and DHEC were identified.

/2013/ The oral health web-based resources and tool kit have been reviewed by clinicians and additional recommendations have been made to increase the effectiveness of the resources within the clinician's setting. Currently 144 QTIP practice staff have been trained in the administration of fluoride varnish; 14/18 QTIP practices are now eligible to provide fluoride varnish. //2013//

/2012/ Kathy Tomashitis has been selected as a committee contributor for the revision of the

Newborn Screening Follow-up document produced by the Clinical and Laboratory Standards Institute (CLSI). CLSI develops and publishes standards and guidelines through a consensus process that involves representatives from government, industry, and the patient-testing professions. Regulatory agencies or accrediting bodies often require that a specific CLSI standard or guideline be followed. //2012//

CSHCN

Transfer of Part C lead agency responsibilities to another state agency has allowed DHEC to increase focus on target population (especially those over age three), while continuing participation in the delivery of Part C services to infants and toddlers and on-going collaboration with Part C lead agency in the State Department of Education.

Over the past year progress has been made in development of a new program data system in CARES. Regional and State staff participated in planning the development of the new system which should begin in the upcoming year. The new data system will improve program capacity for capturing, managing, and evaluating program activities related to CSHCN.

/2012/ DHEC provision of direct care through sponsored clinics has been reduced to those sites that staff and providers have determined to be necessary to assure access to pediatric subspecialty services. Purchase of services for low-income children has been maintained at previous levels despite decreased state funding. All policies governing these payment programs have been reviewed and updated during the past year to assure consistency of administration across DHEC regions. This is the first step in establishing an effective system for monitoring program implementation and services provided by CSHCN integration into the CARES data system. When fully implemented for CSHCN by the end of the fiscal year, the CARES system will not only streamline billing Medicaid and private insurance for covered services, but also improve reporting on services provided. Transition of the state IDEA Part C program from DHEC to the state Department of Education was completed effective July 1, 2011. Camp Burnt Gin staff collaborated with the University of South Carolina Medical Center on a summer session for children with sickle cell disease. While children with sickle cell disease have always participated in the Camp, this was the first time that a session was developed specifically for these children. //2012//

/2013/ Division planning for a comprehensive management information system for CSHCN programs within the agency-wide CARES data system continues, although work on the programming changes has been delayed. No target date for completion of this project has been established, however work is progressing on the changes needed to bill Medicaid and/or private insurance for applicable program services is nearly completed. These changes were necessitated by creation of a central data system (SCEIS) for state agencies. In the meantime, Division staff continue to identify and document data system functions needed for reporting and caseload management. This documentation will be updated and maintained to guide CARES activities when they resume.

SC was awarded its first Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grant in October. The Medical University of South Carolina (MUSC) received the award, but the project is a statewide collaborative effort of MUSC, University of South Carolina, and Greenville Hospital Systems.

An AAP "CATCH" grant will support planning for transition services for children with sickle cell disease in the Low County area of the state.// //2013//

On-going services to 400-450 children annually at Camp Burnt Gin residential summer camp for CSHCN. Most of these children would not otherwise have access to a camp experience.

The DOH in collaboration with the CSHCN workgroup developed training for parents and

childcare providers titled, "Oral Health for the Child with Special Health Care Needs." This training was delivered at the annual Family Connections Conference in March 2010, and at EdVenture's "Celebrating Children with Disabilities" conference. These events targeted parents, caregivers, teachers and providers of children with special needs.

Surveillance, Epidemiology, and Evaluation

The ongoing development and integration of health and health services data remains a priority for the Bureau. Over the past year the Research and Planning Unit has used vital records data, including linked birth/infant death files to provide key data and information to policy makers. Staff has also utilized PRAMS data to examine various aspects of maternal health. Studies examining the oral health of pregnant women have been used to support efforts of the Oral Health division and resulted in an oral presentation at the MCH Epi conference. Additional studies utilizing vital records linked to Medicaid billing data to examine gestational diabetes, prenatal care and postpartum diabetes screening have also been conducted and will be submitted for publication in the upcoming year.

/2012/ The MCH Bureau is planning to collaborate with the SC Rural Health Research Center on dissemination of data analysis results on gestational diabetes, prenatal care, and postpartum diabetes screening. Dissemination of these data will enhance the capacity of the MCH Bureau to address these issues. //2012//

/2013/ Manuscripts reporting results on gestational diabetes, prenatal care, and postpatum diabetes screening were published in Women's Health Issues. Additionally, an analysis of trends in infant sleep positioning in SC was published in the Maternal and Child Health Journal. Analyses that were published by the SC MCH Bureau include four fact sheets/issue briefs focusing on late preterm births, infant mortality, cesarean deliveries, and influenza vaccination among pregnancy women. Finally, a Mother and Child Health Data Book covering issues relating to infant, child, and maternal health along with data about MCH programs such as Family Planning, WIC, and Pospartum Newborn Home Visits. MCH Bureau staff is also serving as preceptors for multiple graduate student practica that will result in deliverables. Topics for these practica include examining infant mortality in SC through a Perinatal Periods of Risk (PPOR) framework, a comprehensive assessment of breastfeeding in SC, and an evaluation of a teen-friendly family planning clinic model.

Materials published by the MCH Bureau are distributed through several mechanisms. Electronic and hard copies are distributed to physicians and staff in the state's birthing hospitals through the Perinatal Regionalization network. Furthermore, hard copies of publications are distributed at meetings of the Agency Director's Pediatric Advisory Council and Obstetric Task Force meetings as well as at meetings of the SC Birth Outcomes Initiative. Electronic and hard copies are also distributed to partners such as the SC Chapter of the March of Dimes and the SC Campaign to Prevent Teen Pregnancy. All of these materials are also made available on the MCH Bureau website.//2013//
An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Since the beginning of SFY 2008 South Carolina has experienced significant budget reductions that have continued through the assessment period. Entering SFY 2010-2011 recurring State funds to the agency have been cut significantly. Efforts to secure one-time funds to offset some of the reductions are often met with mixed results. The ongoing fiscal challenges have resulted in a significant overall loss of workforce capacity. State and local public health departments have been forced to eliminate positions or leave vacancies unfilled at all levels. The impact of fiscal challenges permeates all programs and activities and erodes the critical public health infrastructure in the state. Voluntary retirement incentives have been instituted as a cost

containment measure. This has accelerated the departure of many seasoned public health professionals and further decreased agency capacity to meet basic needs.

Despite the decreased capacity for providing direct services, MCH staff continues to increase their span of influence by working in conjunction with other state agencies and partners. MCH staff provides extensive input into design and implementation of service delivery systems through participating in community coalitions, advisory boards, joint cross-agency grant writing efforts, needs assessments, and public information efforts. Regional and Central Office program staff participate in the development and implementation of evidence-based interventions that target statewide and local issues related to improving the health and well-being of MCH populations.

/2012/ Key partnerships assure effective utilization of all funds. Culturally competent care is a focus to address disparities. Work with local Hispanic leaders across the state is impacting service delivery at all levels. //2012//

Comprehensive, Community Based, Coordinated, Family Centered Care

Promoting family centered care, community based coordination of services, and community based systems of care remains a priority. MCH supports medical home services in pediatric and family practices through on-going collaboration with the state AAP chapter. The division works closely with Family connections by providing planning and implementation support of the Family Connection annually conference which works to get parents and providers critical information to improve care for special needs children. At the Regional level, staff works diligently at resource referral activities for both families and providers. Most children have access to primary care; however, access to subspecialty pediatric care is not uniformly distributed and access can be challenging for families residing in rural areas. The Division of CSHCN is working with the network of Children's Hospitals to promote and develop community-based networks of care, linking families with providers.

At the state level, there is considerable interaction with First Steps to School Readiness (First Steps). First Steps was named the lead agency for BabyNet services in January 2010. The Nurse Family Partnership (NFP) is also an initiative of First Steps. The Duke Endowment and the Blue Cross Foundation provided funding for the implementation. The extensive home visitation history of the public health agency has been invaluable to First Steps during this initial phase of development.

/2012/ In South Carolina, there are currently six NFP sites, which offer evidence-based home visitation to first-time low-income mothers and their babies. Four of the sites are implemented through DHEC and serve clients in the following counties: Anderson, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Horry, Lexington, Richland, and Williamsburg. Recent efforts led to expansion of services into three counties. In total, the sites implemented by DHEC are serving approximately 400 mothers and their babies. There are efforts underway across the state to increase the communities where NFP is available to first-time mothers. In Greenville and Spartanburg Counties, NFP is implemented through their respective hospital systems. Currently, the program is funded by grants and through public-private partnerships. Efforts are underway at the state level to build a state infrastructure for NFP to support its continued growth and sustainability. //2012//

/2013/There are now seven NFP sites, serving 19 counties. DHEC continues to facilitate four of the sites, which serve approximately 425 mothers and their babies. In January 2012, Carolina Health Center NFP began serving families in five counties through its federally qualified health center.//2013//

SC was one of ten states recently awarded a 5 year Centers for Medicare and Medicaid CHIPRA grant. The SC award is for $9.2 million dollars. The goals built into the grant come directly from MCH's long-term work on medical homes, and more recently the ECCS Implementation plan.

This project has 4 key goals: demonstration the newly-developed quality indicators can be successfully utilized in pediatric practices; share key clinical data through a statewide electronic quality improvement network; develop a physician-led peer-to-peer quality improvement network; and expand the use of pediatric medical homes to address mental health challenges of children. MCH staff is on the Planning and Steering Committee for this grant.

/2012/The 2011 CATCH (Community Access To Child Health) SC AAP meeting was held in conjunction with the CHIPRA -- QTIP (Quality through Technology and Innovation in Pediatrics) grant's first learning collaborative in January 2011. The MCH ECCS grant funded a large portion of the CATCH meeting. DHEC's Deputy Commissioner for Health Services, Dr. Lisa Waddell made the opening presentation to over 120 pediatricians and their staff to update them on the changes in public health services and particularly to those affected by severe budget cuts. Four of the 25 quality indicators that are a focal point of the QTIP 5 year grant were presented at the CATCH meeting with practitioners sharing their experience with Plan, Do, Study, Act cycles for quality improvement. Four new quality indicators will be introduced at the biannual QTIP learning collaborative meetings, which are always coupled with the SC AAP meetings.//2012//

Expected outcomes of the CHIPRA grant are to: provide feedback to CMS on quality indicators; improve access to and satisfaction with mental health services for children/adolescents/families; increase utilization of validated developmental and mental health screening tools; increase number of National Committee for Quality Assurance (NCQA)-certified pediatric practices; increase Health Information Technology (HIT) adoption and utilization; increase skill in collecting CHIPRA quality measures; provide a transferable and scalable data collection method that will be useful to a variety of practices; and provide differential reimbursement for NCQA certified (level 2 and 3) Patient-Centered Medical Home (PCMH) practice.

/2013/In February 2012, the CATCH (Community Access To Child Health) SC AAP meeting was held. Over 160 people including pediatricians, their staff, and public health regional and state office leaders attended. Asthma management was the featured quality improvement measure. Other topics address were services to help families find resources for child/adolescent mental health and substance abuse, the Help Me Grow replication project, and integrating family support programs into health care settings.

The QTIP grant continues to focus on the following quality indicators in the 18 participating practices: developmental screening, well child visit completion rates to 15 months, ER usage, ADHD management, access to care, family centered care, oral health, asthma, low birth weight, c-sections, prenatal care, behavioral health management and NCQA Medical Home guidelines. The 18 practices have reported on over 300 PDSA cycles performed this year.//2013//

/2012/Brenda Martin, MCH Bureau Director, presented at the SC Primary Care Association facilitating increased partnership and networking opportunities to support increased access to care.//2012//

Preventive and primary care services for pregnant women, mothers and infants

MCH provides a variety of preventive and primary care direct services for pregnant women, mothers, and infants. Direct services are limited to four areas: family planning, pregnancy testing, postpartum newborn home visiting (PPNBHV), and Nurse Family Partnership (NPF). From 2003-2007 the family planning caseload decreased by 19%. A workgroup devised strategies to improve access to family planning services yielding activities that have seen caseload numbers increase. County health departments continue to provide pregnancy testing for women. Improving referral systems for both positive and negative tests has been a focus area for recent performance management activities.

/2012/Despite severe economic challenges, including a decrease in the nursing workforce, SC's FP Caseload only decreased by 1% in CY 2010. A greater decline in caseload was averted by increasing clinical efficiencies through ongoing Patient Flow Analysis (PFA) training, the re-opening of a clinic targeting teens on Johns Island, offering non-traditional clinical hours to accommodate people's work and school schedules, and the adoption of centralized appointment by most Public Health Regions. A partnership with the SC Campaign to Prevent Teen Pregnancy has produced a media campaign and teen friendly web site. Challenges include increasing contraceptive costs, Medicaid provider reimbursement cuts, as well as potential abuse of the current SC reporting law.

A workgroup, with representation from each health region, the MCH Bureau, WCS, the DHEC Office of Performance Management, and the Office of Nursing, has worked to create a target caseload for each health region. The FY 2011 target caseload for the state is 93,767. Each health region has implemented efficiency recommendation to combat loss of staff resulting from Medicaid and state budget cuts. The efficiency plan is critical to the effort to increase the statewide FP caseload.//2012//

/2013/The FY 2011 Family Planning caseload was 90,252. The program did not achieve the target caseload due to continued staffing decline; however, the program continues its focus on efficiencies to maintain as much caseload as possible with existing resources.//2013//

PPNBHV have been a longstanding Title V program strategy. These early home visits serve as a gateway for assuring infants are connected to pediatric primary care, and mothers are connected to family planning services during the post partum period. Agency capacity to provide these visits has been severely impacted by staff shortages and Medicaid Managed Care reimbursement challenges. Considering these challenges, in SFY09 16,203 PPNBHVs were provided.

During SFY10, 11,756 PPNBHVs were provided by DHEC staff in SC, despite additional cuts in staff and the challenges of negotiating reimbursements from Medicaid Managed Care organizations. In response to severe staff limitations in some areas, MCH developed a list of priority groups to receive PPNBHVs when visits had to be curtailed in a Region, allowing staff to focus upon groups likely to benefit most from visits.

/2013/During SFY 2011, there were 9,076 Post-Partum New Born Home Visits (PPNBHV) provided by DHEC staff. Funding and staff limitations made it necessary to reduce the number of PPNBHVs; however, the highest risk cases have been deemed a priority.//2013//

/2012/Nurse-Family Partnership (NFP) has been newly implemented in SC. Four 4 local health departments currently house the program, serving approximately 400 first-time Medicaid eligible mother. Recent funding stemming from health care reform should result in a significant expansion of NFP into other counties.

The Nurse-Family Partnership (NFP) serves first-time, Medicaid-eligible mothers and babies. Through public-private partnerships, NFP is supported in several counties across the state. NFP clients in 8 counties are served by DHEC. Recent funding stemming from health care reform may support the future expansion of NFP into additional counties. Children's Trust was named the lead agency for SC Maternal, Infant, and Early Childhood Visiting funding, and the MCH Title V Director works closely with them on the development and expansion of home visitation in the state.//2012//

MCH also has capacity to provide certain enabling services to this population. The program for Women, Infants, and Children (WIC) is within the MCH Bureau and is a critical resource for health food provision and education regarding healthy food choices/lifestyles. WIC food vouchers, nutritional education, and breastfeeding services to pregnant and postpartum women layer services at the foundation providing front line impact with the service population. About half of

the state's pregnant women participate in WIC services.

The WIC Regional Directors plan to increase capacity in support of breastfeeding through use of The Business Case for Breastfeeding training. This training is part of a national initiative of the U.S. Health & Human Services, HRSA's Maternal and Child Health Bureau to increase breastfeeding duration and exclusivity rates among employed breastfeeding women.

/2012/MCH Bureau and WIC developed a draft of an agency Breastfeeding Strategic Plan in an effort to increase breastfeeding initiation and continuation rates. The Division of WIC partnered with the MCH Bureau Director and the DHEC Division of Nutrition, Physical Activity and Obesity to conduct a SWOT Analysis of current breastfeeding initiatives and procedures provided in the state. The SWOT Analysis revealed strengths and several opportunities for improvement. The analysis resulted in four main recommendations for WIC staff moving forward. The goals are: 1) Promote and support exclusive breastfeeding for all mothers; 2) Assure all WIC staff members are knowledgeable and skilled in breastfeeding promotion and support; 3) Assure WIC is recognized as a community resource for breastfeeding promotion and support; and 4) Facilitate SC WIC agencies and the National WIC Association advocacy for the development and implementation of local, state, and federal policies and procedures that protect, support, and promote breastfeeding. Detailed action steps have been identified to make progress toward each goal.//2012//

/2013/In collaboration with the MCH Bureau Director and other MCH partners, the State Director for the Office of Public Health Nutrition at DHEC has led the effort to develop of a strategic plan to improve breastfeeding rates in South Carolina. In June 2012, a breastfeeding workgroup was added to the BOI structure, recognizing the desire for South Carolina Hospitals to be designated as Baby-Friendly. The group will also work toward each of the objectives based on the 2011 Surgeon General's Call to Action to Support Breastfeeding.//2013//

Population based programs include newborn metabolic screening, birth defects surveillance, and newborn hearing and FIMR. The newborn metabolic screening program continues to provide screening and follow up for every infant born in the State. The program currently screens for 28 metabolic disorders recommended by the March of Dimes and the American College of Medical Genetics and an additional 24 secondary metabolic disorders also causing severe problems early in life. The program provides active follow up for ~100 infants last year. Lab fee increases for metabolic screening implemented during the past year will allow the program to sustain the current level of screening.

/2012/The newborn metabolic screening program conducted an extensive feasibility analysis related to screening for Severe Combined Immunodeficiency Disease (SCID). The program will not implement screening for SCID until the results of pilot testing in other large states are completed.//2012//

/2013/The newborn metabolic screening program convened a study group of public and private stakeholders to make recommendations regarding Critical Congenital Heart Defects screening. Several hospitals are screening despite no state requirements to do so. A letter was sent to all pediatric and obstetric providers to inform them of the screening recommendation and the study group's findings. Regional Perinatal Staff will maintain an updated list of hospitals that have fully implemented screening.//2013//

The South Carolina Birth Defects Program (SCBDP) has lost a significant amount of capacity over the past year; however, the program has been able to continue surveillance for 42 of 45 defects recommended for surveillance by the National Birth Defects Prevention Network. The program continues to partner with the Greenwood Genetic Center to improve birth defects surveillance and prevention efforts in the State. Under the Birth Defects Prevention Act, the SCBDP entered into a MOA designating the GCC to act on behalf of the program for NTD

prevention efforts.

/2012/The South Carolina Birth Defects Program has been able to continue surveillance for 41 of 45 defects recommended for surveillance by the National Birth Defects Prevention Network. The program continues to partner with the Greenwood Genetic Center (GGC) through a MOA designating the GCC to act on behalf of the program for Folic Acid awareness/education and NTD prevention efforts. The Program has also developed a process of outreach to inform families of children with birth defects of the services available to them.//2012//

/2013/The South Carolina Birth Defects Program (SCBDP) resumed surveillance of one cardiovascular defect, and now provides surveillance on 42 of the 45 defects recommended for surveillance. Furthermore, the SCBDP is adding functionality to data collection systems to provide surveillance on the use of pulse oximetry to screen for these CCHDs.//2013//

The Newborn Hearing Screening Program has improved and expanded capacity for surveillance and follow up activities. During the past year the program has been successful in streamlining the programs data system infrastructure to create a comprehensive record for each child screened and requiring follow up. This will provide more accurate program surveillance and follow up data.

/2012/The Newborn Hearing Screening Program has completed its effort to streamline the program's data system infrastructure. Additionally, the program has completed the audiology diagnostic module to add to the hospital screening module already in place. The program is currently working on the development of the tracking and follow-up module to be incorporated in the single, streamlined database. The plan is also to include a capacity to collect outcome data for those receiving early intervention services by collaborating with the South Carolina School for the Deaf and Blind, a key early intervention provider.//2012//

/2013/The Newborn Hearing Screening Program launched the tracking and follow-up module of the streamlined database system that is integrated with Vital Records. Additionally, the program staff and extended team volunteers have participated in the NICHQ Learning Collaborative for newborn hearing screening.//2013//

The Division of Oral Health produced recommendations/guidelines for oral health care and pregnant women. Postcards announcing the web-based resources for the recommendations and referral forms were sent to 260 obstetricians, family practitioners and midwives across the state.

/2013/The Division of Oral Health provides resources and the workshop, Oral Health Before, During and After Pregnancy, for expectant mothers.//2013//

MCH continues to support local FIMR efforts; however, local capacity to support the process has been greatly reduced with only 9 of 46 counties maintaining active local FIMR groups.

/2012/Over the past year, the number of counties maintaining an active FIMR has reduced to only 4 of 46 counties. Despite the diminishing capacity to sustain the program at the local level, the MCH Bureau continues to support FIMR as a critical program and activity. Therefore, staff at the state level has worked to build internal capacity to take the lead of FIMR. Local level groups are unable to conduct case reviews; therefore, a state team will review the deaths, create a summary of findings, and make recommendations to the local level so that community action can still occur. Extensive work at the state level has been done to create an electronic database to facilitate ease of data entry and data sharing. This database is expected to be operational by the end of 2011. A state review team has also been identified. This team will consist of key internal MCH staff, Public Health Statistics and Information Services (PHSIS) staff, and community stakeholders. The MCH Bureau will also work with the Health Services Office of Performance Management to track the statewide implementation of the new FIMR process.//2012//

/2013/In September 2012, the MCH Bureau conducted the first meeting of the State Infant Mortality Review Committee. The Committee extensively reviews infant deaths occurring at the five Regional Perinatal Centers as well as all sleep-related infant deaths throughout the state.

Discussions have begun regarding the need for a Maternal Mortality Review. Legal opinions have been sought and further justification is being developed for the Agency Director's approval. It is recognized that stakeholders will need to be brought together and the issue discussed.//2013//

MCH also invests in infrastructure building activities directed at this population. MCH is working to improve capacity for providing epidemiological and program information to stakeholders. Efforts to integrate surveillance program data within existing web-based platforms have been successful. Birth defects surveillance and newborn hearing data are both housed within the Birth Exchange Engine (BEE). During the past year, components of the newborn hearing program data system previously supported by separate applications were migrated to the BEE. This should improve the accuracy of surveillance and follow up activities for this program.

/2012/The new FIMR database will be a module within the BEE system. This addition will allow integration of FIMR and Birth Defects Surveillance data.//2012//

/2013/The FIMR database is not yet operational; however, data is being collected in preparation for use of the electronic system.//2013//

/2012/SC DHEC was named as the lead state agency for the Personal Responsibility Education Program (PREP) 5-year grant and received $760,906 for the first year of funding. We are partnering with the SC Campaign to Prevent Teen Pregnancy (SC Campaign) for the RFP process at the local level and for technical assistance to the subgrantees. In April, the SC Campaign held a bidder's meeting for potential applicants, and we have received 19 grant applications. The subgrantees will be chosen and funding awarded by July 1. Evidence-based programs chosen for this funding are "Making Proud Choices!", "Safer Choices", and "What Could You Do?". The funding for the second year is expected to decrease to $755,337.//2012//

/2013/DHEC contracts with several sexual assault centers throughout the state, which provide sexual violence primary prevention education and awareness by increasing healthy relationship knowledge, skills, attitudes, beliefs and behaviors along with promoting bystander intervention.//2013//

/2012/Staff from South Carolina's toll-free referral hotline, the Care Line, presented at 21 events in 2010. They provided print materials for an additional 63 events targeted at both providers and clients. The Care Line staff received 17,227 calls in 2010. The most frequent questions pertained to access to Medicaid providers, WIC, and household needs (i.e. rent, utilities, and food). The Care Line staff plays an integral role assisting callers as they navigate through the Medicaid system by referring them to the appropriate Medicaid representative in their respective counties. The Care Line also mails out a Medicaid brochure with the eligibility requirements in the pregnancy packets sent out at the caller's request.//2012//

/2013/Care Line staff presented at 22 events in 2011 and provided printed materials for an additional 96 events. There were 16,016 calls received by Care Line staff in 2011, and 1,830 packets of health information were mailed to individual callers.//2013//

Preventive and primary care services for Children

Capacity to provide preventive and primary care services for children has shifted away from direct services. Direct services to children are limited to adolescents receiving services through DHEC

Family Planning and STD/HIV clinics.

MCH does continue to provide enabling services. The School Dental Prevention Program provides preventive dental services to underserved populations. In the 2008-2009 school years, the five programs provided dental sealants for 7,194 children. WIC continues to a significant factor enabling the nutritional development of children in the State. As the economy continues to struggle, need for WIC services among children continue to increase.

Population based efforts related to medical home partnerships continues to be a priority area for MCH.

Infrastructure building activities around services for children is ongoing. The Division of Oral Health, in collaboration with the Coalition's Early Childhood Workgroup, produced oral health recommendations for young children. In March 2010, the DOH received funding from the Academy of Pediatric Dentistry to develop Clinician and Early Head Start Parent Education toolkits as part of SC's Head Start Dental Home Initiative based on the recommendations.

/2012/The DHEC School Dental Prevention Program provides preventive dental services to underserved populations through public-private partnerships. In the 2009-2010 school years, the five programs provided dental sealants for 10,761 children./2012/

/2013/During the 2010-2011 school year, 384 schools in 48 districts were served by the DHEC School Dental Prevention Program. Over 20,000 children were screened, and 9,661 of those children received one or more dental sealants on their molar teeth.//2013//

/2012/DHEC's Division of Oral Health has completed the Head Start/American Academy of Pediatric Dentists (AAPD) Dental Home Initiative Project, which included an Oral Health Tool Kit for Early Head Start/Head Start staff as well as a web-based resource center for clinicians The information and materials within this Clinician Tool Kit/Resource Center are designed to support and strengthen outreach, education and the connection between dentists, clinicians and local Head Start programs. DOH received Year Two funding which will allow the Division to further expand efforts related to the Tool Kit./2012/

/2013/Head Start Health Coordinators received a Tool Kit upon the completion of the Effectively Integrating Oral Health into Early Head Start Programs training, which supported their efforts to expand and strengthen their connection with medical and dental providers.//2013//

/2012/Childhood lead screening follow-up remained a public health priority in the state. Each year, approximately 300 children in SC are affected by lead poisoning. Currently, efforts focus primarily on assisting public and private health care providers statewide in screening children 9 months through 6 years of age for lead poisoning. Children in this age range can receive a lead screening test in a DHEC clinic if the child does not have a medical home and the public health professional has assessed risks indicative of probable lead exposure. Education, counseling, and referral are offered as indicated by the assessment. There are currently no dedicated funds for childhood lead screening follow-up; however, in 2009, Environmental Public Health Tracking (EPHT) funding became available. A portion of these funds are being utilized to pay for the development of an electronic server-based data repository for Lead/Mercury/Heavy Metals data as required by the CDC's EPHT program. The Living Within Our Means process established a pilot project to assist the health regions in childhood lead screening case follow-up.//2012//

/2013/The Heavy Metals database now has one completed year of data, which reflect that statewide, over 35,000 children were tested for lead. A SC Lead Testing Fact Sheet is now available. The State Lead Screening Coordinator has provided consultation and follow-up to over 150 entities including physicians, nurses, Head Start programs, laboratories, and health departments. Agreements have been established with two physicians to provide

consultation to other physicians across the state. This agreement was formulated in response to a request from our active Pediatric Advisory Committee.//2013//

Services for CSHCN

The MCH target population for CSHCN services is children with chronic illnesses or physical disabilities. MCH does not serve children with emotional or behavioral conditions not associated with a chronic illness or physical disability. DHEC staff provides limited direct care in selected locations for specialty clinics. DHEC remains under contract with First Steps to provide a set array of services; however, we are no longer responsible for the oversight and implementation of services to those from birth to 3 with developmental disabilities.

Some enabling services (purchase of care, financial assistance) are provided to children in target population based on income criteria. DHSS contracts with DHEC for the "gatekeeper" role for enrollment of and provision of hemophilia products, orthodontia care and audiological services. Care coordination (assistance with identifying and obtaining needed health care services, beyond mere information and referral) is provided as needed to children who receive financial assistance, and to other children in the target population as resources permit.

Among population based services, MCH provides information and referral services on request of any family member or provider. Nine regional offices for CSHCN services are located in the eight DHEC administrative regions. These offices are usually the first point of contact for families and professionals. Each office is staffed by at least one RN, administrative staff. The offices have varying access to nurses and social worker familiar with local and statewide resources as well as needs of CSHCN and their families. Medical consultation is available at all times to state and local DHEC staff working with CSHCN through contract with the University of South Carolina, Department of Pediatrics.

State level program managers now include two RNs and one social worker with access to nutrition consultation on an as need basis. State level staff process approximately 1000 invoices for covered services each month. Total reimbursement from CRS for these services is in excess of $2 million annually.

Capacity for rehabilitative services for the blind and disabled under 16 receiving SSI benefits is limited. The program receives SSI referrals alerting them to send a letter of notification about additional services and resources. Beyond these activities, the extent of services is limited to those offered by existing CRS programs, such as transition to adult care planning.

/2012/South Carolina maintains excellent sources of medical services for CSHCN at four children's hospitals (Greenville, Florence, Columbia, and Charleston). Regional CSHCN staff facilitate access to these services through information, referral, care coordination and payment for services through CSHCN payment programs covering children up to age 18 with a wide range of medical conditions.//2012//

Culturally Competent Care

All new employees are required to take the Culturally and Linguistically Appropriate Services (CLAS) course within the first year of employment. Additionally, all employees are required to receive refresher training on CLAS annually through the agency's E-Learning System. A copy of the agency policy is available as an attachment for review.

Policies and procedures are also in place to ensure that agency informational/educational materials convey appropriate public health, be culturally sensitive to the intended audience, are available in multiple languages, and are created at an appropriate reading level.

DHEC staff and clients have access to interpreter services through systems established and maintained by the DHEC Office of Minority Health. Bilingual staff are hired for available positions as circumstances allow. Cultural competency training is a required element of DHEC staff orientation. The parent support contractor (Family Connection of SC) also employs bilingual staff and actively recruits bilingual parents for participation in all activities. Information and training sessions related to cultural competence are included in annual Family Connection conference, which is co-sponsored by DHEC.

/2013/DHEC continues to support cultural competency training for staff to assure culturally sensitive delivery of services. This is manifested through culturally appropriate and acceptable educational materials as well as through the availability of interpreter and translation services.//2013//

/2012/In addition, the agency's web site has been designed to make electronic information available to clients using web accessibility assistive technology.

Within the MCH Bureau, the Division of Women and Children Services currently has 77 educational materials for women and children's health available in both English and Spanish. The topics include child health, family planning, newborn metabolic screening, and hearing screening, as well as a variety of written health information from health organizations outside of DHEC, that have been approved for use with DHEC clients. Clinic staff continues to depend on the TeleInterpreter Line for interpretation of languages.//2012//

/2013/The MCH Bureau now distributes 100 educational materials related to the health of women and children. These materials are produced in both English and Spanish.//2013//

MCH staff is active members of the Perinatal Awareness for Successful Outcomes (PASOS) Advisory Council. The PASOS program empowers Latina women in SC to gain access to resources and have healthy families one Paso (step) at a time and provides information in a way that can be understood, supported, and adopted by the community.

/2012/PASOs was named as a promising practice by AMCHP. MCH staff continues to participate on the PASOS Advisory Council.//2012//

Statutes

Although there are no statutes directly mentioning Title V authority, several South Carolina statues have direct implications for DHEC and the MCH Bureau.

Section 44-37-30- Establishes the newborn metabolic screening program with DHEC and requires every child born in the state, with the exception of religious exceptions, to have neonatal testing to detect inborn metabolic errors and hemoglobinopathies.

Section 44-37-40- The Universal Newborn Hearing Screening and Intervention Act requires all hospitals with more than 100 deliveries annually to screen for hearing loss and those with less than 100 deliveries annual are required to inform parents of newborn hearing screening. Those with hearing loss are to be referred for follow up interventions. DHEC maintains oversight and coordination of program activities.

Section 44-38-50- Requires hospitals to make available a shaken baby video informing parents of the dangers of shaking an infant or young child before hospital discharge. DHEC is responsible for approving and making videos available child care providers/facilities.

Section 44-44-10- The South Carolina Birth Defects Act establishes a comprehensive birth

defects program housed at DHEC that is responsible for surveillance, prevention, referral, and reporting of birth defects in the state.

Section 61-16- Requires the state hospitals to organize into a regionalized system of care of newborn care.

Section 44-1-280- Requires DHEC in establishing priorities and funding for programs and services which impact on children and families during the first years of a child's life, within the powers and duties granted to it, must support, as appropriate, the South Carolina First Steps to School Readiness initiative, as established in Title 59, Chapter 152, at the state and local levels.

/2012/Section 44-41 Article 3 Women's Right to Know Act changes the requirements for waiting time prior to pregnancy terminations from 60 minutes to 24 hours after a woman receives and verifies she has had an opportunity to review specific information related to their fetus and its development. DHEC is required to provide specific information on its website for this purpose. Other information that must be provided by DHEC include: 1) a list of agencies which offer alternatives to abortion, 2) a description of medical assistance benefits which may be available for prenatal care, childbirth, and neonatal care, 3) a list of health care providers, facilities, and clinics that perform ultrasounds free of charge, 4) a plainly worded explanation of how a woman may calculate the gestational age of her embryo or fetus, and 5) a scientifically accurate statement concerning the contribution that each parent makes to the genetic constitution of their biological child. The website generates a time and date stamped certification identifying when the materials are downloaded. Providers should retain this form, or one with equivalent content, in the medical record.//2012

/2013/A proviso, 22.46 (Fetal Pain Awareness) was passed, which requires the agency to provide printed material to abortion providers in the state concerning information that an unborn child at twenty weeks gestation and beyond is fully capable of feeling pain and the right of a woman seeking an abortion to ask for and receive anesthesia to alleviate or eliminate pain to the fetus during the abortion procedure. Materials containing this information have been developed and distributed. //2013//
Section 44-29-40- Authorizes DHEC to have general direction and supervision of vaccination, screening, and immunization in this state. It also requires that DHEC establish a statewide immunization registry and develop regulations for the implementation and operation of the registry. All health care providers are expected to report to DHEC the administration of any immunization.

/2013/Section 44-29-40 will be fully implemented once the necessary regulations are passed by the General Assembly.//2013//

Section 40-15-110- Identifies DHEC's role in the Dental Practice Act 2003. DHEC is charged with coordination of the School Dental Prevention Program using public-private partnerships to deliver preventive dental services in public health settings that address the needs of priority populations identified by standard public health principles.

Section 44-8-10- Requires DHEC to identify a Community Oral Health Coordinator, who shall implement a targeted community program for dental health education, screening, and treatment referral in public schools. No funding has been allocated for this effort. DHEC is currently in the process of developing program guidelines for promulgation in regulations.

Section 56-5-6514- Establishes Chandler's Law, which provides regulation of the operation of All Terrain Vehicles (ATVs) by including minimum age requirements, safety course completion, and passenger riding requirements. The law prohibits children under the age of 6 from operating an ATV; requires ATV drivers under the age of 16 to complete an ATV safety course and wear a head and eye protection while operating the vehicle. The law permits exceptions for children on farms, private property, while hunting, or under direct supervision of parents or guardians.//2013//

C. Organizational Structure

The South Carolina General Assembly created the Department of Health and Environmental Control (DHEC) in 1973. The agency is under the supervision of the Board of Health and Environmental Control, which has seven members, one from each of the six congressional districts and one at large. The governor with consent and approval from the senate appoints members. The Agency is headed by the Commissioner, Mr. Earl Hunter and contains four Deputy Areas: Health Services, Health Regulations, Environmental Quality Control, and Ocean and Coastal Resource Management.

/2013/ In March 2013, the SC Department of Health and Environmental Control (DHEC) experienced a change in leadership. Catherine Templeton is the new Director of the agency. Director Templeton has named Jamie Shuster as Director of Public Health and Elizabeth Dieck as Director of Environmental Health. The agency continues to be under the supervision of the Board of Health and Environmental control, which is comprised of seven members who are governor-appointed with advice and consent of the senate. //2013//

DHEC is a centralized public health organization with central, regional, and local public health offices carrying out various aspects of public health practice. At the state office, Health Services has four Bureaus: Maternal and Child Health, Disease Control, Community Health and Chronic Disease, and Laboratory. In addition Health Services has five Professional Offices: Primary Care, Nursing, Social Work, Health Education, and Nutrition.

Oversight of the Title V program is housed within Maternal and Child Health Bureau. The MCH Bureau works centrally to plan, implement, and monitor Title V programs and activities. There are four divisions within the MCH Bureau that carry out aspects of Title V programming. The Division of CSHCN, Women's and Children's Services (WCS), Women Infants and Children (WIC), Oral Health, (DOH) and the Research and Planning Unit (RPU).

The Division of CSHCN contains the Children's Rehabilitative Service Program (CRS), components of BabyNet, Orthodontia, Hemophilia, and Sickle Cell services and Camp Burnt Gin. The Division of WCS contains program areas including Newborn Metabolic Screening, Newborn Hearing Screening, Family Planning, Child/Adolescent Health, Care Line, Sexual Assault Prevention, PPNBHV, and the Early Childhood Comprehensive Systems (ECCS) initiative. ECCS facilitates a leadership group concerned with cross-agency services coordination for children 0-5, including children with special needs. The Division of WIC implements the federal WIC program funded through the Department of Agriculture. The Division of Oral Health contains the School Based Sealant, Water Fluoridations programs, and facilitates the South Carolina Oral Health Advisory Council with workgroups focusing on children, and CSHCN. The Research and Planning Unit houses all Bureau epidemiology activities and contains Birth Defects Surveillance, FIMR, and Perinatal Regionalization.

In addition to the MCH Bureau, Title V funding also supports programs/initiatives within 8 Regions encompassing 46 local health departments. Regional offices and their local health departments offer a range of services. These offices include direct clinical services such as family planning and WIC as well as community based health promotion activities. Each region seats a Health Director, a Child Health Program Manager, Nurse Manager, and other appointments responsible for the planning, implementation, and evaluation of ongoing Title V programs/initiatives. Central office staff works in coordination and collaboration with the regional leadership to develop plans and assure services are provided that are meaningful to each region considering their unique needs.

/2012/ Collaboration has increased with community organizations receiving Title V funding. One example of this is The Children's Trust of South Carolina, which received the Affordable Care Act

funding for evidence based home visitation programs to assure coordination of efforts.

There has also been increased collaboration with Healthy Start, assuring integration of efforts within public health sites. //2012//

/2013/ Collaborative activities continue as noted in previous years. Opportunities for a stronger relationship with SC DHHS have surfaced through the close work done on the Infant Mortality Reduction Plan as well as through the Birth Outcomes Initiative (BOI). In addition, the networking opportunities of the BOI meetings facilitate sharing of programmatic ideas and allow for working together on other projects with other agencies and community partners. The ability to work closely with the SC Hospital Association has facilitated a better understanding of perinatal regionalization efforts, postpartum newborn home visits, immunization follow-up, and many other public health activities.

In an effort to provide public health training to new and veteran staff, DHEC has partnered with the Public Health Training Center (PHTC) at the University of South Carolina to provide education and training opportunities geared specifically to the practice of public health. A "Public Health 101" course was developed collaboratively between DHEC and USC and is a required three-part training for all Health Services staff at DHEC. Additionally, a DHEC Scholars program was created in which DHEC staff can apply for scholarships to earn a Certificate of Graduate Studies in Public Health by taking courses at the USC Arnold School of Public Health in financial management, community assessment, data management, program planning and evaluation, and public health policy and advocacy.//2013//
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Staff working on Title V related programs/initiatives span the agency and include both state and local persons. Within the MCH Bureau staffing capacity has decreased drastically over the past year. Retirements, buy outs, and hiring freezes have reduce the size of the workforce through attrition. Existing staff have added additional duties and have worked to sustain existing efforts.

MCH Bureau

Brenda Martin, RNC, MN, NEA, BC, serves as the MCH Bureau Director and Director of Title V Programming. She is responsible for providing leadership and oversight of MCH programs and activities. Ms. Martin has a long history of public health experience in various roles within DHEC and has also worked in the managed care environment. She brings knowledge, experience, and skills needed to facilitate the complexities of collaboration with managed care organizations. She is also a member of the South Carolina Board of Nursing

Nathan Hale, PhD, serves as the MCHB Deputy Director. He recently earned his doctorate degree in Health Services Policy and Management from the University of South Carolina, Arnold School of Public Health. Mr. Hale serves as the Bureau's lead epidemiologist and manages the Research and Planning Unit. He has held positions in two states as an epidemiologist and a district health director. He is an experienced researcher and has multiple peer reviewed publications.

/2012/ The MCH Bureau Deputy Director position is currently vacant.

/2013/ The MCH Bureau Assistant Director position remains vacant. //2013//

Michael Smith, MSPH has recently joined the MCH Bureau as the MCH Epidemiologist. Mr. Smith received his Master of Science in Public Health from the University of South Carolina. He previously worked for four years with the PRAMS project. Currently, through an internal DHEC

partnership, Mr. Smith continues to work with the PRAMS project while serving as the MCH Epidemiologist, therefore strengthening the relationship of the two areas. Mr. Smith has multiple peer-reviewed publications. //2012//

CSHCN

Cheryl Waller, BSN, MPH, serves as the Director of the Division of CSHCN. Ms. Waller joined DHEC in April 2005 from North Carolina. She also has over 25 years of nursing and management experience at the state and federal levels.

Leanne S. Bailey, RN, serves as the Assistant Director of the Division of CSHCN. She brings over 20 years experience with CSHCN at the regional level in service delivery and program management.

/2012/ The Assistant Director position of the Division of CSHCN is vacant. The position will be modified to meet changing needs of the Division. //2012//

Carole Scott, BSN joined the DHEC Division of CSHCN as a program coordinator in December 2009. She has 14 years of experience working with CSHCN populations and has held several positions at the local and regional level before joining Central Office.

Martha Hinson MSW, LMSW, serves as the BabyNet coordinator. She has 20 years of experience and has been with DHEC since 1994 working at the Regional level, before joining the Division of CSHCN this past year.

/2012/ The BabyNet Coordinator position is now vacant and will not be filled due to the transfer of BabyNet services to another agency. //2012//

WCS

Lucy Gibson MSW, LMSW has served as the director of WCS since July 1, 2008 and the State Adolescent Health coordinator since January 2005. Prior to that she served as the WCS and CSHCN social work consultant and a District Director of Public Health Social Work. Ms. Gibson has been employed by DHEC since 1989. She is a graduate of the UNC Management Academy for Public Health and is credentialed as a Certified Grants Specialist.

Beth De Santis, APRN, MSN, WHNP joined MCH as the Family Planning Director. She brings a wealth of knowledge and experience to this position. She has worked at the regional level for 9 years. Her positions at DHEC have included Family Planning/STD/HIV/Immunization Program Nurse Manager and Clinical Services Director. Ms. De Santis is one of 15 members on the Title X Expert Panel for revising the clinical guidelines in Title X. The goal of this panel is to review all current guidance for medical practice for men and women in the Title X setting.

Kathy Tomashitis, MNS, RD, LD has been the manager of the Newborn Metabolic Screening program since 1994. She also supervises the activities of the Newborn Hearing Screening Program. In addition, Ms Tomashitis provides consultation to the Division of CSHCN regarding special and metabolic formula requests for eligible children.

Tara Carroll, MCD, CCC/A is an audiologist and has served as program manager for DHEC's newborn hearing screening program and audiology consultant to Children's Rehabilitative Services and BabyNet (Part C) since February 2005. Prior to that she practiced audiology for 10 years in non-profit United Way community agencies and an ENT physician's office.

Rosemary L. Wilson, MSW, LMSW has served as coordinator for the Early Childhood Comprehensive Systems Initiative since 2006. Prior to this she worked 15 years in a district office and duties included management of care coordination for CSHCN, systems coordination for

BabyNet Part C, community outreach coordinator. She has 30 years of social work experience with children and families in school, hospital, and mental health settings.

Jane Key, MPA is currently the Sexual Violence Services Program Coordinator and has held this position since September of 2003. She is also serves as the State Women's Health Director having had this additional position since February of 2009. She is a graduate of the University of South Carolina (USC) Public Administration program and recently completed all requirements for the Arnold School of Public Health at USC Public Health Certificate Program.

Sarah Fellows is a Certified Pediatric and Family Nurse Practitioner with 25 years' work experience with SC DHEC. She currently serves as the Child Health Program Manager and Family Planning Nurse Consultant in the Division of Women and Children's Services

/2013/Sarah Fellows retired this past year.

Maxine Williams, MS, APRN, FNP, BC has been hired as the Family Planning Nurse Consultant. She has a wealth of clinical and management experience. Ms. Williams previously worked at the region level.//2013//

/2012/ Martha Hinson, MSW, LMSW, has been hired as PREP Grant Coordinator and State Adolescent Health Coordinator. Mrs. Hinson has a bachelor's degree in Behavioral Science from Erskine College and a Master's degree in social work from the University of South Carolina.

Sara Beth King, MPH, BSN, has been hired as the State Nurse Consultant to the Nurse Family Partnership (NFP) Program. Ms. King has a Bachelor's degree in Nursing from Binghamton University and a Master of Public Health degree from Benedictine University. Her nursing experience in maternal and child health has been primarily in the public health setting. For the past three years, she worked as a nurse home visitor with the NFP Program in both New York and North Carolina. Currently, her role as State Nurse Consultant is to provide clinical support and consultation to the NFP sites in the state. //2012//

WIC

Burnese Walker, MS, RD serves as the WIC Director. She has over 20 years experience working with WIC programs in two states (Georgia and South Carolina). She has also worked with School Food Services at the SC Department of Education.

/2013/ The Division Director position for WIC is now vacant. Ms. Walker retired in late May 2012. Plans are to have the position filled by mid-August 2012. //2013//

Oral Health

Christine Veschusio, M.A., serves as the Oral Health Division Director. She has been with the DOH since October 2002. Before becoming the Division Director, she served as the School Program Coordinator and the Project Director for the Robert Wood Johnson Foundation More Smiling Faces in Beautiful Places program. She also practiced clinical dental hygiene and was an Associate Professor for Horry-Georgetown Technical College before joining DHEC.

Carol Reed, MPH, has over 5 years experience with MCH in Systems of Care and the Medicaid MEGA Administrative Services Contract. She joined the Division of Oral Health in August 2009 as the Program Coordinator for the Centers for Disease Control Oral Health Cooperative Agreement. She also continues to work with the MEGA Contract in the areas of medical/dental homes, Family Planning Waiver, and Medicaid utilization/eligibility.

/2013/The Program Coordinator position for the CDC Oral Health Cooperative Agreement is currently vacant. The MEGA Contract responsibilities of the person previously in the

position have been transferred to Breana Lipscomb, MCH Planning and Evaluation Coordinator.//2013//

Wes Gravelle, MPH currently serves as an epidemiologist and surveillance coordinator for the Division. He also provides limited support for MCH Bureau epidemiology activities. Mr. Gravelle has worked for several state agencies in various roles focused on data and surveillance.

Research and Planning Unit

Breana Lipscomb, MPH serves as the state FIMR coordinator and has been with MCH for 2 years. In addition to FIMR duties, Ms. Lipscomb is also involved in numerous perinatal projects MCH planning activities including the 2010 needs assessment.

/2012/ Breana Lipscomb now serves as the MCH Planning and Evaluation Coordinator. Her duties include coordination of the Title V Block Grant, DHEC Regional MCH Plans, perinatal projects, and the FIMR program. //2012//

Kirk Shull, B.S., serves as the Research and Planning Administrator for the Birth Defects program. Mr. Shull has over 20 years experience working with data, information systems, and GIS functions within the agency. In addition to maintaining the BEE, Mr. Shull's duties include the development of additional program data within MCH

/2013/The Birth Defects Program Research and Planning Administrator position is currently vacant.//2013//

/2012/ Amy Nienhuis, LISW-CP, MSW serves as the Special Perinatal Project Consultant. She works extensively with physicians around the state to assure statewide regionalization efforts remain stable. Mrs. Nienhuis has 15 years of experience working with the MCH population. //2012//

/2013/ The Special Perinatal Project Consultant position is currently vacant. //2013//

Parents of Special Needs Children

First Sound, the state's Early Hearing Detection and Intervention (EHDI) Program, does employ a parent that serves as a DHEC volunteer. Her key focus is to establish an SC chapter of Hands & Voices, a parent-driven, non-profit organization providing families with the resources, networks, and information they need to improve communication access and educational outcomes for their children who are Deaf and Hard-of-Hearing.

There is no position in the CSHCN division filled by a parent to provide leadership and technical assistance around issues uniquely parenting related. An agency-wide survey is under development to determine the number of DHEC employed parents also have children with special health care needs. They would be asked to volunteer as a parent liaison/advisor on a variety of program planning, evaluation outreach activities. Family Connection, SC parents most often provide this needed support to the Bureau.

/2013/ The agency survey to identify parents of CSHCN was not completed. It will be pursued as a means of obtaining family input for future block grant applications. Funding was identified to expand parent education and support services provided by Family Connection of SC (Family Voices) to children and youth receiving DHEC services. Goals and objectives for these expanded services were based on frequent discussions over the past two to three years regarding opportunities for increased parental involvement in delivery of DHEC programs and services for CSHCN. At least one part time parent advisor will be assigned to each CSHCN office. Protocols to standardize services are being

developed, however flexibility will be maintained based on regional needs and resources. This is a very exciting development for the Title V program. //2013//

E. State Agency Coordination

Unlike most State agencies, DHEC is not a member of the Governors cabinet; however, the agency maintains close working relationships with staff at fellow human services agencies. MCH collaborates with all related state agencies and multiple private organizations to prioritize needs, avoid duplication of service and effort, and blend resources to meet needs. As our capacity continues to decrease, this coordination within and among State Agencies is a critical priority. Several examples illustrate the type of State Agency Coordination MCH continues sustain.

External Coordination

Department of Health and Human Services (Medicaid)-Coordinating with DHHS/Medicaid is critical for MCH operations. The MCH Bureau works with DHHS at multiple levels related to numerous aspects of health services for mothers and children. DHHS is represented on multiple MCH sponsored councils/committees that include: Commissioners OB Task Force and Pediatric Advisory Council meetings, ECCS Executive Committee, Oral Health Advisory Council and Coalition, the South Carolina Birth Defects Advisory Council, Commissioner's Pediatric Advisory Committee, and Commissioner's Obstetric Task Force. Individual programs within the Bureau coordinate activities with DHHS on an ongoing basis. The Division of CSHCN meets regularly with DHHS and MCO representatives to coordinate services and payment of services for children with special needs. Representatives from WCS and Family Planning coordinate activities related to the Family Planning waiver and access to contraceptive services for eligible women. The Bureau maintains a large administrative contract with DHHS for the purposes of enrollment outreach and selected services for children and pregnant women. Perinatal Regionalization staff coordinates with DHHS on aspects of perinatal services related to maternal/fetal transport as well as infant back transport from the Regional Perinatal Centers. MCH staff also participates in the Medicaid Medical Advisory Council and Medicaid Managed Care Council.

/2012/SC DHHS has recently initiated a "Birth Outcomes Initiative", which facilitates collaboration among key stakeholders to address birth outcomes. Dr. Lisa Waddell, DHEC's Deputy Commissioner of Health Services, will serve as a member of the "Vision Team". The first meeting of the team has been held and has set the stage for considerable work to address the multifaceted issue of low birth weight.//2012//

/2013/The Birth Outcomes Initiative (BOI) has greatly expanded during the past year. This group was convened by SC DHHS. Key participants include DHEC, March of Dimes, SC Hospital Association, Office of Research and Statistics, USC School of Medicine, Healthy Start, SC First Steps, private OB practitioners, PASOS, and numerous other stakeholders. At its inception in July 2011, the group's chief goal was to improve the health of newborns in the Medicaid program. The BOI's scope has broadened to include private payers and now focuses on the health of all mothers and their newborns. The extensive external coordination within the BOI has been critical to the numerous policy and systems changes have been initiated and/or implemented through the work of this group. DHEC and the SC Hospital Association will jointly fund a position to coordinate perinatal activities within the hospitals that support improved birth outcome initiatives.//2013//

WCS

Representatives from WCS are also represented on the Evidence Based Home Visitation Coalition, NFP Advisory Board, First Steps Board of Trustees, and the Early Childhood Advisory Council.

/2012/The MCH Bureau Director is a key member of the NFP Advisory Council working directly with private funders to facilitate DHEC's role in the NFP arena. The MCH Bureau Director has also been designated to represent the DHEC Commissioner on the First Steps Board and the ECAC Advisory Board.

The ECCS Coordinator is also a member of the CHIPRA QTIP Planning and Steering Committee.//2012//

The ECCS Leadership Committee includes representatives of SC Departments of Social Services (DSS), Health and Human Services (DHHS) (Medicaid Agency), Mental Health (DMH), Education (DOE), Disabilities and Special Needs (DDSN), Alcohol and Other Drug Abuse Services (DAODAS), Head Start, First Steps (SCFS), Children's Trust of South Carolina (CTSC), Office of Research and Statistics (ORS), and Family Connection.

/2012/Representatives from the March of Dimes, United Way, and the SC American Academy of Pediatrics Chapter also serve on the ECCS Leadership Committee.//2012//

With 2010 funds for implementation, ECCS has contracted with Dr. Francis Rushton, a Beaufort Pediatrician, and AAP Region 4 board member to continue his leadership in working with individual pediatric practices to examine quality measures to enhance their role as a medical home. Another contract is with the SC AAP to lead an annual CATCH meeting bringing practices across the state together for a learning collaborative around quality improvement. With the USC School of Medicine, Department of Neuropsychiatry there is a contract to provide state leadership in advancing training and service provision around early childhood mental health and social emotional issues, and with the USC College of Education, a contract will support cross-agency training using the Center for Social Emotional Foundations of Early Learning (CSEFEL) modules.

/2012/ECCS is entering the final year of the grant cycle. The contract plans for this year include continuation of funding for each of the 2010 contract providers. One additional contract will support the Help Me Grow National Replication project in SC to build the system component of a call center/single point of entry for developmental concerns. The Center for Social Emotional Foundations of Early Learning (CSEFEL) contract will provide preparing our state certified trainer in CSEFEL 0-3 and preschool in their special parent focused training materials. //2012//

/2013/In April of 2012 it was determined by HRSA that the ECCS grant period would be extended for one year. The ECCS Leadership Team is determining current contracts for continuation. Next steps for CSEFEL training will be examined, as well as the feasibility of other social-emotional development and mental health training in child care consultation. Further support to the Help Me Grow replication project will also be considered in a new contract.//2013//

MCH has a long history of collaboration with the Department of Education. The Division of WCS employs a School Nurse Consultant who works across agencies to promote the health of children in schools. The School Nurse Consultant is responsible for coordinating school health activities in the state. An example of the partnership between these agencies and the local Boards of Education was their joint plan to address last years H1N1 pandemic to provide school based immunizations. Participation in immunizations at school-based clinics was well received and many children were immunized for H1N1 through the schools. Until recently, WCS has also employed a School Social Work Consultant who coordinated school social work activities on a statewide basis. The ability to refill this position is uncertain at this point in time.

/2013/MCH continues its collaboration with the Department of Education to employ a State School Nurse Consultant to promote healthy outcomes and optimal educational outcomes for school-aged youth in grades kindergarten through twelve. The School Nurse Consultant works with education agencies (K-12), public health staff, and community practitioners to provide school screening and referral recommendations, facilitate

continuity of care for students with special healthcare needs, assure required immunizations, and maintain an infrastructure for acute disease surveillance. The School Social Work Consultant position was eliminated due to budget constraints. WCS continues to assist SC's School Social Work Association by updating their website and helping with electronic registration for both their spring and fall conferences.//2013//

The Sexual Violence Services Program has contractual and coordinating relationships with all the domestic violence and sexual assault centers as well as the State Coalition Against Domestic Violence and Sexual Assault (SCADVASA).

Adolescent Health and Family Planning work closely with the SC Campaign to Prevent Teen Pregnancy.

The WCS Division Director is a member of the Community Engaged Scholars Program Advisory Board, a partnership between a large FQHC, Eau Claire Cooperative Health Centers, Inc. and the Medical University of South Carolina. This partnership was formed to evaluate the Vitamin D status of pregnant women and their newborns with a particular focus on women of color due to studies reporting severe Vitamin D deficiencies in these populations.

MCH provides technical assistance to regions for program development, implementation, and evaluation. Staff often provides community-based training programs on specific topics such as postpartum depression, sexual violence prevention, abuse and neglect, and a variety of health issues.

/2012/WCS staff continue their involvement with all entities specified in the 2011 report. In addition 3 staff members are serving on a recently-formed leadership collaborative for agencies and foundations involved with teen pregnancy prevention in SC. Staff participated in the 2010 SC Council on Children and Adolescents Policy Forum. This event was hosted by DMH and DAODAS to encourage screening, referral, and access to services for children and adolescents in SC, utilizing the "No Wrong Door" approach. Wanda Crotwell, the DHEC Assistant to the Commissioner for External Affairs, and the MCH Bureau Director have been involved with the aforementioned council regarding policy decisions.//2012//

/2013/Lucy Gibson and Rosemary Wilson have worked with the Children's Law Center this year in facilitating DHEC's response to the Joint Citizens and Legislative Committee on Children's Annual Report. This committee was created by statute to research issues regarding the children of South Carolina and to offer policy and legislative recommendations to the Governor and the Legislature. In this year's report, 4 critical areas were chosen for action: Childhood Obesity, Childhood Immunizations, Safe Sleeping Practices, and Trauma-Informed Practices (chosen because "undiagnosed child trauma affects physical health, academic achievement, teen pregnancy and juvenile crime and can have a profound negative effect on adulthood"). The full report is available at: http://www.sccommitteeonchildren.org/doc/2012_AnnualReport.pdf
DHEC has been named lead agency to address Childhood Obesity and Immunizations. An agency workgroup was convened to meet with the Children's Law Center, who serves as staff for this committee, review the report, designate leaders and group members to work on action plans, and discuss ways to involve external stakeholders. DHEC also has 3 staff members participating on the Safe Sleep Workgroup, led by SC Children's Trust, and 2 staff members contributing to the Trauma-Informed Practices Workgroup.//2013//

/2012/The MCH Bureau Director will be presenting at the Annual School Nurse Conference focusing on DHEC MCH services for the school age population.//2012//

CSHCN

DHEC staff (state and local) routinely collaborates with counterparts in state departments of mental health, social services, education, human services (Medicaid), vocational rehabilitation regarding planning and implementation of service for CSHCN. There exists an on-going contractual relationship with Family Connection (Family Voices) for parent support services. The DHEC Commissioner's Pediatric Advisory Committee meets quarterly to advise the Commissioner and the MCH Director on issues that include CSHCN. Staff maintains regular working meetings with early intervention service providers related to services for CSHCN under age five. Both state and local staff regularly communicates with counterparts in mental health, social services, education, and human services (Medicaid) regarding eligibility, service, and payment needs.

/2013/The Division of CSHCN continues to maintain all of the aforementioned external partnerships and collaborations to more effectively provide services to the CSHCN population.//2013//

Oral Health

The Oral Health Division continues to facilitate the SC Oral Health Advisory Council and Coalition. The Advisory Council includes representation from Medicaid/SCHIP, FQHCs, Department of Education, the dental school, Head Start, Healthy Start, First Steps, community members and other agencies and organizations. This group reviews and makes recommendations on policy and practice issues that emerge from DHEC and the coalition workgroups. The workgroups contain broad stakeholder membership and are responsible for moving the SOHP forward. In addition, a DOH representative also participates in the Early Childhood Comprehensive Systems group.

/2012/During this year, the SC Oral Health Advisory Council and Coalition have worked collaboratively on policy issues including the development of an oral health component for the School Health Index, the development of the regulations for the Dental Screening and Community Oral Health Coordinator Act 125 (2010), and the DHEC-South Carolina Dental Association Mercury Reduction Initiative.

The DOH is collaborating with the SC American Academy of Pediatrics (SCAAP) on quality measures related to oral health. The measures will be discussed at the SCAAP meeting in July 2011.

The DOH has partnered with the NFP Program to positively impact the oral health of mothers and babies through integration of oral health education and outreach into the NFP Program curriculum.//2012//

/2013/The Division of Oral Health Director, Christine Veschusio, presented The Power of Prevention: Spending Smarter to Improve Dental Health, a Congressional briefing sponsored by the PEW Center, for the State's Children's Dental Campaign. The goal of the session was to present state efforts to improve dental health in cost effective ways that yield long term savings through prevention and private partnerships. In addition she co-authored a journal article titled, Rural-urban differences in dental service utilization among an early childhood population enrolled in South Carolina Medicaid along with partners from the University of South Carolina and the SC Office of Research and Statistics.//2013//

Other Program Coordination

Title V continues to limit direct services that include EPSDT. Local health departments no longer routinely provide EPSDT services. Instead, the role has shifted to provision of assurance that services are being provided. MCH monitors EPSDT services and works to improve the provision of services within a medical home. Title V also works close with other providers of direct services. The Title X Family Planning Program and WIC both reside within the MCH Bureau.

Organizational alignment of these programs within the MCH Bureau promotes coordination of services. Family Planning and WIC represent the few remaining MCH programs that provide direct or enabling services to women and children. Title V works to coordination services with populations utilizing these direct services.

/2012/Nurse-Family Partnership projects are in 7 DHEC sites across the state and are recognized for the public health enhancements to the delivery of services; 2As+R tobacco cessation referal, breastfeeding education (including the role of the father to support breastfeeding), education regarding the Benefit Bank, Postpartum Newborn Home Visits, and oral health education. The project success depends on community and organizational coordination. Expansion efforts are ongoing; 2 hospital sites cover 2 additional counties. //2012//

Internal Coordination

In addition to the provision of services with the Bureau, MCH also coordinates activities with other DHEC Bureau's/Programs on related services. Notable efforts include efforts related to tobacco cessation, motor vehicle crashes, obesity prevention, and immunizations.

/2013/The Bureau of Community Health and Chronic Disease Prevention (BCHCDP) is constantly seeking to enhance levels of coordination, collaboration, and communication within the Bureau and across Health Services for the purpose of maximizing resources and reducing the potential for duplication of efforts. Therefore, the BCHCDP works to implement its assigned public health efforts (many are categorically funded) across five functional areas. These areas include: surveillance and epidemiology, community/clinical linkages, health promotion-health risk reduction, health communications, and continuous quality improvement and evaluation. The BCHCDP views chronic disease prevention from a broad perspective, and sees tremendous value in the complimentary approaches being supported by MCH services. As such, BCHCDP constantly works to integrate MCH staff members (and others) into each functional team efforts to maintain a life-course focus on chronic disease prevention. Further internal coordination is demonstrated by the Bureau Directors from MCH and BCHCDP participating in each business units monthly Management Team Meetings.//2013//

The Division of Tobacco Prevention and Control (Bureau of Community Health and Chronic Disease Prevention) has several initiatives pertinent to pregnant women, mothers and infants. In addition to efforts targeting smoke free ordinances, the division also received stimulus funds to target tobacco reduction efforts among pregnant women. The program targeted counties with a high density of pregnant smokers and ran a pregnancy-focused TV ad. The South Carolina Tobacco Quitline has seen an increase in the number of pregnant women calling for services.

/2012/Since launch date of August 16, 2006, the Quitline has served 323 pregnant tobacco users, 146 of whom registered for cessation counseling services between July 1, 2010 and April 30, 2011. A new agency policy requiring internal provider referrals to the Quitline from all programs including WIC and Family Planning programs has helped increase the reach to this population along with the media campaign targeting pregnant smokers. On March 4, 2011, the Tobacco Division distributed to maternal and child health partners an announcement about the new CME Provider Online Training "2As+R Brief Tobacco Intervention" and requested that the MCH Bureau disseminate the announcement to their maternal and child health provider networks. The MCH Bureau promoted the online training to 240 of our provider networks. The Tobacco Division is partnering in 2011-2012 with the SC DHHS, their Medical Home Networks (MCNs), and the state alcohol and drug abuse agency to implement the October 1, 2010 federal Patient Protection and Affordable Care Act mandate that the State's Medicaid program comply with Title IV, Subtitle B, Sec. 4107 -- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid.//2012//

/2013/Since the launch date of August 16, 2006, the SC Quitline has served 690 pregnant tobacco users, 246 of whom registered for cessation counseling services between July 1, 2011 and April 30, 2012. The Tobacco Division continues to partner with SC DHHS, SC Department of Alcohol and Other Drugs and Substances, and the Department of Mental Health to implement the Patient Protection and Affordable Care Act mandate that the State's Medicaid program comply with Title IV, Subtitle B, Section 4107.//2013//

/2013/Screening, Brief Intervention, Referral and Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The target population is Medicaid Members who are Pregnant, and the focus is on Tobacco, Substance Use Disorders (alcohol/other drugs), Depression, and Domestic Violence. In this project, the role of the Tobacco Division staff is to provide guidance and technical assistance to all seven Medicaid Health Plans -- the Medicaid Medical Home Networks (MHN) and Managed Care Organizations (MCO) and their providers on the SBIRT component to address tobacco cessation intervention through the S.C. Tobacco Quitline. The ultimate outcome of the project is to capture and track data on the pregnant members referred to the Quitline by Medicaid providers through the SBIRT initiative and determine the level of services received, hopefully leading to a successful quit attempt.//2013//

/2012/The FP program incorporates 2As+R into all initial and annual visits by asking clients if they smoke or use tobacco products. If yes, the client is provided counseling along with a recommendation to quit. The client is then asked if they are interested in a referral to the SC Quitline. If the client agrees, the referral is made. The 2As+R information has been added to the adult clinical encounter form to ensure appropriate documentation. A similar process is in place for other MCH programs. The WIC program has a formal Memorandum of Agreement with the Division of Tobacco Prevention and Control to carry out these assessment and referral activities. //2012//

/2013/In the current fiscal year, there have been a total of 876 fax referrals to the SC Quitline from DHEC sites, including MCH and other program areas.//2013//

Motor vehicle crashes are the leading cause of death among children over the age of one. The Child Passenger Safety Program within the Bureau of Community Health and Chronic Disease continues working to prevent and reduce deaths and injuries due to motor vehicle crashes through outreach education, counseling and demonstration of proper car seat instillation, and training.

Through the ECCS partnership with DSS and the states Child Care Block Grant leadership, the Division of Childhood Obesity is working on policy changes in state requirements for child care centers related to nutrition and physical activity. Recent activities include aligning nutrition and physical activity standards across multi programs, and offering bonus reimbursement to centers that participate in assessment of their practices coupled with an improvement plan.

/2012/The Bureau of Community Health and Chronic Disease coordinates the State Child Fatality Advisory Committee, which reviews unexpected and unexplained child deaths that occur in South Carolina. The goal is to reduce the incidence of preventable child deaths by developing an understanding the causes of child death. Approximately 200 cases are reviewed each year by a multidisciplinary team. The team develops recommendations to prevent children from unintentional, intentional, undetermined, and natural deaths for children aged 0-17. Staff from the MCH Bureau participates on this Advisory Committee.//2012//

//2013//The Office of Healthy Schools is a liaison office between DHEC and the State Department of Education and is working to promote school health and safety of students, faculty, and staff. Its primary focus to date has been the 8 Components of Coordinated

School Health, the CDC's School Health Index assessment, and the SC Healthy School Awards Program. However, it is also working on Safe Routes to School efforts and has a partnership with the Safe Routes to School Resource Center and the SC Department of Transportation's Safe Routes to School Program.//2013//

/2012/The Immunization Division (Bureau of Communicable Disease) has a new Division Director with a strong MCH background, which has strengthened the propensity for the Immunization Division and the MCH Bureau to share information. In July 2010, a presentation was made to the SC Chapter of the AAP which focused on the need for increased accountability for federally funded vaccines and appropriately serving insured children with privately purchased vaccines. At the 2011 SC AAP Conference, the Immunization Division will sponsor an exhibit on the immunization registry.//2012//

The Immunization Division is currently working with the SC Hospital Association and Medicaid to cocoon newborns and infants, too young to receive an initial DTaP vaccination, against pertussis. A task force has been formed to address Tdap protocol for postpartum areas, educating the mother concerning her infant's risk for pertussis and offering Tdap vaccination to these mothers prior to hospital discharge.

/2013/The Immunization Division continues to work closely with the MCH Bureau and Vital Records Division within DHEC as well as the SC Hospital Association (SCHA), SC DHHS, SC Chapter of American Academy of Pediatrics (AAP), SC Academy of Family Physicians (SC AFP), and the Birth Outcomes Initiative (BOI) workgroup. An electronic survey of birthing hospitals in SC for current policies and practices for perinatal communicable diseases was completed in May 2012 in collaboration with the SCHA, MCH Bureau and BOI. A medical record abstraction for a sampling of 2011 births is underway during calendar year 2012. Findings on the administration of the birth dose of Hepatitis B vaccine will be compared to data obtained through the electronic birth certificate. Information gathered from both of these efforts will be shared with stakeholders through the BOI workgroup for future planning. The Immunization Division and MCH Bureau will partner for an exhibit at the July 2012 SC AAP Conference.//2013//

Increasing coordination and alignment with other Bureau programs is a priority issues for the upcoming 5 year planning cycle.

MCH also works very closely with the Office of Public Health Statistics and Information Systems (PHSIS) within the Commissioners Office on projects related to data and information systems. MCH has worked with PHSIS to develop web based surveillance systems for certain programs, create web based data modules allowing access to MCH related data including vital records, PRAMS, and BRFSS, and provided GIS support for ongoing mapping projects.

/2012/ Furthermore, in April 2011 primary data analysis responsibilities for SC PRAMS moved from PHSIS to MCH. Additional collaboration has occurred between SC PRAMS and the WIC program. WIC staff will provide SC PRAMS with contact information (primarily telephone numbers) for WIC clients that provide informed consent. This will help to reverse the decreasing trend in the SC PRAMS response rates which will, in turn, provide higher quality data. //2012//

/2013/MCH continues to hold primary data analysis responsibilities for PRAMS data. This has resulted in a great deal of analytic collaboration between MCH and PHSIS in the past year which has resulted in the publication of four fact sheets, one academic poster, and one data book utilizing birth certificate, PRAMS, and SC Birth Defects Program data. Additionally, the SC WIC Program has begun to provide contact information to PRAMS for women that provide informed consent in order to improve the survey response rate.

The MCH Epidemiologist routinely participates in the Bureau of Community Health and Chronic Disease's Epidemiology and Surveillance Team's monthly activities. Currently, MCH funds 25%

of the Child Health Assessment Survey, which is coordinated by the Bureau of Community Health and Chronic Disease.

The MCH Bureau also actively collaborates with the Emergency Medical Services for Children (EMSC) Program as well as the Division of Injury and Violence Prevention in regards to child safety. The EMSC Program has coordinated travel to various child injury prevention conferences with focuses on child maltreatment, car seat safety, safe sleep promotion, bicycle safety, and other injury prevention measures. MCH staff serves as a member of the EMSC Advisory Committee, as well as the SC Injury Free Alliance, which is coordinated by the Division of Injury and Violence Prevention.

F. Health Systems Capacity Indicators

The outlined Health Systems Capacity Indicators serve as important measures for obtaining a broad sense of the existing capacity of the health system for mothers and children. Annual reporting of these indicators allows MCH to fill our assurance role by monitoring specific capacity measures and providing feedback to partners related to trends and areas of need.

/2012/ MCH has maintained and enhanced collaborations with the Office of Public Health Statistics and Information Systems (PHSIS) by providing State Systems Development Initiative (SSDI) Grant funding for continued development of the SC Community Assessment Network (SCAN), a web-based application that provides queryable access to data on MCH and other populations, and the Birth Exchange Engine (BEE), a web-based data entry and management system for the Birth Defects Hearing Screening programs. Additionally, DHEC Health Services, which houses the MCH Bureau, has an MOA with the SC Office of Research and Statistics (ORS), which is the repository for much of SC's medical systems data, including data from Medicaid, the State insurance plan, hospital discharge, and emergency departments. The availability of data from these various sources provides the MCH Bureau with access to data covering much of the MCH population. A notable gap in the data coverage is population-based data among South Carolinians from 1 to 18 years of age. To address this data need, the MCH Bureau is working with the Bureau of Community Health and Chronic Disease Prevention to establish funding for a child health assessment and monitoring survey that will be a follow-up to the BRFSS survey. //2012//

/2013/ MCH has maintained and expanded collaborations with the Office of PHSIS. Major upgrades of the Newborn Hearing Screening and Birth Defects Surveillance modules in the BEE system are now live. We anticipate implementing a Fetal and Infant Mortality Review BEE module in the coming year. Additionally, the Environmental Public Health Tracking Program (EPHT) within PHSIS has partnered with the Birth Defects Surveillance Program to display Birth Defects data in dynamic tables and maps on the EPHT website. Due to concerns over small numbers, these maps are only available at the perinatal region level (four regions in South Carolina). Additionally, frequencies and rates are suppressed if there are fewer than five of the queried birth defect in a perinatal region. Finally, the South Carolina Child Health Assessment Survey (SC CHAS) is in the first year of data collection as a BRFSS follow-up survey on the health and behaviors of South Carolinians from 1 to 18 years of age. SC CHAS is being coordinated by the Bureau of Community Health and Chronic Disease Prevention with input and guidance from MCH.

Health Systems Capacity Indicator 1:
The rate per 10,000 children less than five years of age that were hospitalized for asthma increased slightly from 30.1 in 2010 to 30.4 in 2011. Though this increase was small, it was the second slight increase in two years and warrants close monitoring in SC.

Health Systems Capacity Indicator 2:
According to provisional data, the percent of Medicaid enrollees <1 year of age receiving an EPSDT increased slightly from 81.8% in 2010 to 83.5% in 2011. This indicator continues

to remain mostly stable. However, it is important to better understand the population not receiving EPSDTs and whether the private sector has absorbed clients that might have received EPSDTs from the health department clinics. To this end, MCH has partnered with a researcher at the University of South Carolina School of Public Health to investigate this further through a grant funded by the Robert Wood Johnson Foundation. Additionally, discussions have occurred with the Pediatric Advisory Committee regarding the need to address this issue with the physician community.

Effective July 1, 2012, SC DHHS is updating the periodicity schedule for EPSDT services to include eight (8) additional preventive visits for recipients less than 21 years of age. This policy change will be applicable to all Medicaid providers, including fee-for-service, Medical Home Networks, and Managed Care Organizations. This increase in the number of preventive visits allowed can have a positive impact the health of South Carolina's children because it provides more opportunities for early identification of acute or chronic health issues.

Health Systems Capacity Indicator 5A:
The overall percentage of low birth weight infants remained the same from 2009 to 2010; however, the magnitude of the disparity between Medicaid and non-Medicaid low birth weight infants increased. Disorders related to short gestation and low birth weight continues to be among the leading causes of infant death in South Carolina. Efforts of the statewide Birth Outcomes Initiative will hopefully have a positive impact on low birth weight deliveries and decrease the disparity that exists between Medicaid and non-Medicaid infants. The Birth Outcomes Initiative partners have discussed prevention of low birth weight as an indicator to reduce infant mortality.

Health Systems Capacity Indicator 5B:
In 2010, there was a slight increase in the overall infant mortality rate for the State. The rate increased among births paid for by Medicaid, and the rate among births with non-Medicaid payor sources declined. The magnitude of the disparity between the two groups increased, which closely mirrors the trend with low birth weight infants. The Birth Outcomes Initiative partners have discussed prevention of low birth weight as an indicator to reduce infant mortality. The development of the infant mortality reduction strategic plan has brought heightened awareness to the issue.

Health Systems Capacity Indicator 5C:
The overall percentage of pregnant women receiving prenatal care in the first trimester increased from 2009 to 2010. The rate among pregnant women on Medicaid increased whereas the rate among non-Medicaid women decreased. Promising practices identified in the Robert Wood Johnson Foundation multi-state learning collaborative for prenatal quality improvement continue to be implemented in the participating counties. Additionally, in Beaufort County, the Together for Beaufort Coalition continues efforts to improve prenatal care data quality that is included on the birth certificate. Since the Together for Beaufort Coalition has been active, the prevalence of adequate or adequate plus prenatal care in Beaufort County has increased from 56.6% of live births in 2008 to 73.9% of live births in 2010.

Health Systems Capacity Indicator 5D:
There were decreases in the prevalence of women having adequate or better prenatal care utilization among both Medicaid and non-Medicaid populations from 2009 to 2010. However, the proportion of women with adequate or better prenatal care utilization is nearly equivalent in the Medicaid and non-Medicaid populations in 2010.

Health Systems Capacity Indicator 6B:
The level for Medicaid eligibility has not changed; however, in preparation for the Affordable Care Act implementation in 2014, SC DHHS has increased efforts to enroll as

many children as possible who are currently Medicaid eligible. One such effort is called "Express Lane Eligibility". This automatically deems eligibility for those children who receive free and reduced lunches and whose families receive SNAP (Supplemental Nutrition Assistance Program) or TANF (Temporary Aid to Needy Families) benefits.

Health Systems Capacity Indicator 7A:
Using all children at less than 200% of the poverty level in the numerator and denominator, the percent of potentially Medicaid-eligible children who have received a service paid by Medicaid increased from 73.6% in 2010 to 75.9% in 2011, comparable to the 2009 level.

Health Systems Capacity Indicator 7B:
The percent of EPSDT eligible children aged 6-9 years who have received any dental services remained level in 2011, at 68.5%. Although the enrollment increased 4.5%, the number who received care increased proportionately.

The same contributing factors remain in effect. The School Dental Prevention Program administered by DHEC in partnership with public and private providers continues to play a role in the administration of services, while the active engagement of all partners in the SC Oral Health Advisory Council and Coalition have all impacted access to dental services. As mentioned before, the Dental Practice Act that allows hygienists to provide preventive dental services under general supervision in a public health setting has increased availability to dental care providers.

Health Systems Capacity Indicator 8:
SC maintains a system to assure that all SSI referrals received through the SC Department of Vocational Rehabilitation are provided with information regarding available services and resources. Data on the number of children receiving direct care or enabling services through DHEC who are also receiving SSI benefits will be available in early August.

Health Systems Capacity Indicator 9A:
MCH has maintained the same level of access to and use of multiple sources of data as the previous year. Partnerships, both internal and external, that facilitate access to MCH-pertinent data remain strong.

Health Systems Capacity Indicator 9B:
MCH access to YRBS and Youth Tobacco Survey data has remained unchanged. //2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Beginning in FY 2008 South Carolina has experienced significant budget reductions that have continued through the assessment period. This has resulted in a significant overall loss of capacity. State and local public health departments have been forced to eliminate positions or leave vacancies unfilled at all levels. The impact of fiscal challenges permeates all programs and activities and erodes the critical public health infrastructure in the state.

These realities provide a backdrop for the focus of the needs assessment, and establishment of future priorities. Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity and developing performance measures that are measurable and practical. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

B. State Priorities

Completion of the 2010 needs assessment provided the opportunity to re-focus State priorities and establish new directions for the next 5 year planning cycle. To complete the assessment MCH staff complied data and information using both quantitative and qualitative methods, conducted quasi-focus groups with providers to obtain perspective on health and health service needs, held key stakeholder meetings around each of the established MCHB population groups to review and discuss relevant data and information, conducted site visits to each of 8 DHEC public health regions to gain local perspective on needs and capacity, and utilized various components of CAST-V methodology to assess current capacity to perform core public health functions and essential services. MCH leadership compiled all available information stemming from the assessment process to establish priority areas of need and associated performance measures for the next five year planning cycle.

Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity and developing performance measures that are measurable and practical. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

The new priorities include:
1. Improve overall pre/inter-conception health status of South Carolina women (Infrastructure Building Service)

/2013/ State Performance Measure 1: Increase the number of perinatal regions with an established pre/inter-conception health coalition working to identify and address pre/inter-conception health needs of women //2013//

2. Reduce the annual rate of maternal deaths (Infrastructure Building Service)

/2013/ State Performance Measure 9: Reduce the annual rate of maternal deaths //2013//

3. Reduce the number of infant deaths due to SIDS/Unsafe sleep environments (Enabling/Population Based Service)

/2013/ State Performance Measure 2: Reduce the percent of combined infant deaths due to SIDS and accidents due to unsafe sleeping environments //2013//

4. Increase the knowledge of appropriate child social-emotional development among parents and early childhood service providers (Enabling Service)

/2013/ State Performance Measure 3: Increase the percent of early childhood service providers trained in social/emotional development using an established evidence based curriculum //2013//

5. Improve systems for obtaining parental involvement in the planning, implementation, and evaluation of DHEC programs and services for CSHCN (Infrastructure Building Service)

/2013/ State Performance Measure 4: Increase the number of parents or caregivers participating in the planning, implementation, and evaluation of DHEC programs and services for children with special needs //2013//

6. Promote and support regional based planning of MCH programs/initiatives (Infrastructure Building Service)

/2013/ State Performance Measure 5: Increase the percent of public health regions that plan, implement, and evaluate at least one optional program in each of four established MCH population groups //2013//

7. Increase the degree to which MCH is actively engaged in ongoing assessment and assurance activities (Infrastructure Building Service)

/2013/ State Performance Measure 7: Increase the number of epidemiological reports completed, distributed, and available to agency leadership and partners //2013//

8. Improve coordination of activities related to existing performance MCHB National Performance Measures with a focus on those outside of the MCH Bureau (Infrastructure Building)

/2013/ State Performance Measure 8: Increase the percent of MCHB National Performance Measures with a formal improvement plan that includes measurable goals, objectives, and benchmarks to evaluate progress towards improvement //2013//

9. Invest in building existing MCH workforce leadership competencies and skills related to data analysis and program evaluation (Infrastructure Building Service)

/2013/ State Performance Measure 6: Increase regional satisfaction with the quality of technical support provided by MCH Central Office staff //2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	112	111	163	151	151
Denominator	112	111	163	151	151
Data Source		MCH	MCH	MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Newborn Screening data is consistently one calendar year behind, and it takes at least 6 months after the close of the year to have provisional data.

Notes - 2010
2010 data reflect provisional estimates based on 2009 figures.

a. Last Year's Accomplishments
The Newborn Metabolic Screening Program conducted an extensive feasibility analysis related to screening for Severe Combined Immunodeficiency Disease (SCID) in September 2010. The program will not implement screening for SCID until the results of pilot testing in other large states are completed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contact medical provider to initiate follow-up process for infants with screening results outside of normal limits			X	
2. Track infants with screening results outside of normal limits to case resolution			X	
3. Inform parents of infants whose specimen was deemed unacceptable for routine reporting of test results			X	
4. Perform routine assessment of system of care for infants and children with conditions identified through metabolic screening to ensure that all affected persons are identified promptly and appropriate treatment initiated			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Newborn Metabolic Screening Program continues tracking and appropriate notification procedures. Additionally, the program convened a study group of public and private stakeholders to make recommendations regarding implementation of screening for Critical Congenital Heart Defects (CCHD). Several hospitals have begun screening even though there are no state

requirements to do so. The metabolic screening medical consultant sent a letter to all pediatric and obstetric providers as a means to inform them of the screening recommendation and the study group's findings. The issue has been discussed with the Pediatric Advisory Committee for feedback on how to approach the medical community with the recommendations.

The Program Manager served as a committee contributor for the revision of the Newborn Screening Follow-up document produced by the Clinical and Laboratory Standards Institute (CLSI). She is also the public health follow-up representative to the Laboratory Workgroup of the Newborn Screening Translational Research Network.

c. Plan for the Coming Year

The program will continue to evaluate the appropriateness of screening panel expansion as recommended by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. The program will participate in a study with Emory Genetics to help establish treatment protocols for infants identified with Duarte Galactosemia.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**55599**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	55813	100.4	6	3	3	100.0
Congenital Hypothyroidism (Classical)	55813	100.4	1543	16	16	100.0
Galactosemia (Classical)	55813	100.4	359	1	1	100.0
Sickle Cell Disease	55813	100.4	79	79	79	100.0
Biotinidase Deficiency	55813	100.4	7	0	0	
Cystic Fibrosis	55813	100.4	165	9	9	100.0
Other Amino Acid Disorders	55813	100.4	518	3	3	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	55813	100.4	222	1	1	100.0

Medium-Chain Acyl-CoA Dehydrogenase Deficiency	55813	100.4	7	5	5	100.0
Other Organic and Fatty Acid Disorders	55813	100.4	280	6	6	100.0
Other Sickle Cell Trait	55813	100.4	1650	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	80	80	65	65
Annual Indicator	59.4	60.4	60.4	60.4	73.6
Numerator	93727	93727	93727	93727	126986
Denominator	157801	155101	155101	155101	172559
Data Source		CSHCN	CSHCN	CSHCN	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	85	90	95	100

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
SC continues to rely on national data for direct measurement of performance. During recent years, there has been a steady increase in services for Spanish-speaking families through community-based, culturally appropriate services sponsored by Family Connection and the University of South Carolina. Specifically, the USC PASOS program was recognized by AMCHP as "A Promising Practice", and went on to win the 2012 AMCHP award for "Promising Practice of the Year" for work with Latino families in 13 of SC's 46 counties.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish broad-based advisory group, including parents				X
2. Develop routine procedures for disseminating information and receiving feedback from stakeholders (families, providers, State agencies, etc.) regarding Division CSHCN programs and services				X
3. Create mechanisms for full utilization of CARES data for program management and monitoring of service delivery in regions				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Consumer satisfaction data is routinely collected by DHEC for all services; however, the Division of CSHCN is exploring mechanisms for expanding family satisfaction data collection from families receiving CSHCN services to provide more direct assessment of performance on this measure.

c. Plan for the Coming Year
Collaboration with Family Connection (Family Voices) has been enhance through expansion of the contractual agreement with DHEC, which now includes assignment of parent support staff to each CSHCN office, and creation of a parent advisory council to the Division of CSHCN. This expansion of parent support services resulted from close work with Family Connection over the past few years to identify elements of the desired system of support services for CSHCN served by DHEC.

The Division of CSHCN will pilot test questions about satisfaction with DHEC CSHCN services upon exit from services and/or periodically during the time children are receiving CSHCN services through DHEC. In addition, we will review similar data collection efforts of other state agencies and organizations serving the target population to identify opportunities for comparison of data and/or enhancing data collection and analysis.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	95	95	95	55	55
Annual Indicator	50.6	53.1	53.1	53.1	45.3
Numerator	79820	79820	79820	79820	77480
Denominator	157801	150264	150264	150264	170925
Data Source		CSHCN	CSHCN	CSHCN	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	49	54	59	64	69

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The CHIPRA QTIP (Quality Through Technology and Innovation in Pediatrics) grant completed their second year of the five-year award. To date, the 18 participating practices have addressed several quality indicators, including: developmental screening, well child visit completion rates to 15 months, ER usage, ADHD management, access to care, family centered care, oral health, asthma, low birth weight, c-sections, prenatal care, behavioral health management and NCQA Medical Home guidelines. The 18 practices have reported on over 300 PDSA cycles performed

this year. Each of the practices has also had a data feed from the statewide electronic database that compares them with their peers.

DHEC continued to contract with Family Connection to obtain best-practice consultation on working with families as well as ensuring appropriate referrals are made. Under a separate, expanded contract with Division CSHCN, parents will be involved in direct provision of information regarding identification and optimal utilization of medical homes with families served through CSHCN programs. The DHEC Care Line also makes referrals to medical homes. In addition, providers of Postpartum Newborn Home Visits (PPNBHV) and the Nurse-Family Partnership prioritize connection to medical homes during their visits. Medical Home issues are frequent topics of discussion in the Director's Pediatric Advisory Committee meetings. Dr. Francis Rushton continues to serve as DHEC's Medical Home Consultant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue intra-agency collaboration to support medical home activities				X
2. Prioritize use to Division resources to support medical homes through provision of care coordination services required to fill identified service gaps				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues the strong partnership with CATCH. In February 2012, the CATCH (Community Access To Child Health) SC AAP meeting was held for the second time in conjunction with the third CHIPRA -- QTIP (Quality through Technology and Innovation in Pediatrics) grant's learning collaborative. The Early Childhood Comprehensive Systems grant, managed care agencies, and the SC AAP chapter are the primary sponsors of the meeting. Dr. Lisa Waddell, MP, MPH was the keynote speaker with the topic of Maternal and Child Health at the Crossroads. Over 160 people including pediatricians, their staff, and public health regional and state office leaders attended. Quality Improvement measures featured were asthma management with speakers who addressed Smoking Cessation Counseling for Parents and the Family Connection parent to parent education through Project Breathe Easy. The Federation of Families also presented on their services to help families find resources for child/adolescent mental health and substance abuse. Additional presentations included a Help Me Grow replication project update and a presentation about integrating Family Support programs into Health Care settings.

Also, the new Director of SC DHEC has continued to convene the Pediatric Advisory Committee that serves as a forum for discussion of medical home issues and priorities. An area of concern recently expressed by the pediatricians is the number of children that are assigned to their practi

c. Plan for the Coming Year

ECCS 2012-2013 funding will continue support for the CATCH grant set for January 2013. Contracts with Family Connection will be extended, and the MCH Bureau will continue to work collaboratively with the Federation of Families for Children's Mental Health as well as Parents

Reaching Out To Parents of South Carolina, Inc. (PRO-Parents), a parent training and information center for families of children with special needs.

Jackie Richards, Executive Director of Family Connection, will continue to serve as SC's AMCHP Family Delegate.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90	90	65	65
Annual Indicator	60.1	61.2	61.2	61.2	54.1
Numerator	94845	94845	94845	94845	93799
Denominator	157801	155099	155099	155099	173314
Data Source		CSHCN	CSHCN	CSHCN	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59	64	69	74	79

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

With regard to DHEC programs, analysis of orthodontic program coverage and services was conducted to assure most effective use of available resources. Updates were made to eligibility determination process, coverage and application procedures resulting in streamlining processes, reduction in provider paperwork and better use of resources. Information about Medicaid and Title V orthodontic services in other states was critical to this process. No major changes were made to state insurance coverage requirements related to services for CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain of programs for purchase of services, supplies, and equipment for eligible children		X		
2. Utilize enhanced data systems (CARES) for program management and monitoring of program activities				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Coverage through CSHCN payment programs is under review as part of policy revisions. The CSHCN Division is working with orthodontists and other providers to assess coverage for children with craniofacial anomalies and to assure access to comprehensive, interdisciplinary care.

c. Plan for the Coming Year

When conversion to the new data system is complete in September 2012, the Division of CSHCN will review service and expenditure trends over past three years in order to identify opportunities to better address unmet needs with Title V CSHCN funds.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	85	85	65	100
Annual Indicator	59.8	91.7	91.7	91.7	63.9
Numerator	94339	143848	143848	143848	110357
Denominator	157801	156846	156846	156846	172674
Data Source		CSHCN	CSHCN	CSHCN	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70	70	75	75	80

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Family Connection of SC strengthened collaborations with the state's major pediatric treatment centers to help assure links to, or on-site parent support services for CSHCN beginning in neonatal intensive care units. Policy changes completed for DHEC programs for CSHCN were made to assure statewide consistency in eligibility determination and to streamline the procedures for completing applications and make eligibility determinations. The policy changes made the process simple enough application and approval for most services can now be done on-site in regional CSHCN offices. This can reduce time required to respond to requests for services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of medical homes development and maintenance based on local needs				X
2. Streamline process for eligibility determination and authorization for payment of medical services, supplies and equipment through existing DHEC programs				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
As planned, policy changes developed this year will improve and standardize delivery of DHEC services to CSHCN.

c. Plan for the Coming Year
Full implementation of policy changes will once again be the focus for the coming year. Delays in completion of policy development activities has prolonged the process; however, the final revisions will positively impact the CSHCN services provided by DHEC.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	92	94	94	50	40
Annual Indicator	41.4	37.2	37.2	37.2	41.0
Numerator	22093	22093	22093	22093	28533
Denominator	53358	59389	59389	59389	69664
Data Source		CSHCN	CSHCN	CSHCN	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	45	50	55	60	60

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
This was the final year for DHEC direct involvement with the state IDEA Part C program and activities related to transition from early intervention to pre-school services. Camp Burnt Gin continues to devote sessions to young adults. Camp activities incorporate opportunities for developing and using skills necessary to support independence.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve inter-agency collaboration related to transition planning for CSHCN				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Greenville Hospital Systems, in association with LEND grantees, convened a roundtable discussion on transition issues for children with disabilities to promote better transition planning based on the National Alliance for Secondary Education and Transition (NASET) transition toolkit for systems improvement. Participating organizations are using the toolkit to examine transition services. An AAP "CATCH" grant will support planning for transition services for children with sickle cell disease in the Low County area of the state.

c. Plan for the Coming Year
Revisions to current DHEC policies regarding preparation and documentation of transition plans for children and youth receiving CSHCN services will be completed and implemented in the coming year. Best practices implemented within the state will be identified and documented.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90	90	85	74
Annual Indicator	81.6	78.8	68.0	77.7	76.5
Numerator	97920	96136	82368	71987	70875
Denominator	120000	122000	121130	92648	92648
Data Source		Immunization	Immunization	Immunization	Immunization
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	85	90	95	95

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

a. Last Year's Accomplishments
The Immunization Division worked closely with immunization partners and key stakeholders to obtain input into the proposed immunization registry regulation. Immunization coverage rates for children were maintained.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regionally, assist private providers in tracking infants and young children who are delinquent in primary immunization series			X	
2. Health departments track infants who are delinquent in primary immunization series	X			
3. Health departments utilize WIC clinics to discuss, with mother, the importance of up to date immunizations for their infant	X			
4. Continue to recruit providers to use the state immunization registry, either by direct entry or by submitting data electronically via HL7				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The VFC program and a parallel STATE Vaccine Program were implemented statewide on July 1, 2012. These programs included increased requirements for vaccine accountability as of July 1, 2012. An online system called the South Carolina Immunization Provider Access System (SCI PAS) was implemented on June 15, 2012 for enrollment and re-enrollment in the VFC program. In July 2011, the Immunization Division exhibited at the Annual Conference of the SC AAP on the immunization registry and proposed immunization registry regulation. Work continued throughout this time period to gain immunization stakeholder support and to write the proposed regulation for the mandatory statewide immunization registry. The DHEC Board approved the proposed immunization registry regulation on June 14, 2012 for it to move forward to the SC Legislature for consideration. The reporting of immunization data via HL7 electronic data transfer increased significantly during this time period. As of March 2011, 4 providers were submitting immunization data to the registry via HL7. As of June 14, 2012, 63 providers were submitting immunization data via HL7.

A school entry requirement for pertussis vaccine (Tdap) for seventh graders effective August 2013 was announced to immunization providers and schools in March 2012.

c. Plan for the Coming Year

Work will continue to assure accountability and safety of publicly funded vaccines. Use of the statewide immunization registry will continue to be promoted with immunization providers. The immunization registry regulation will be sent to the SC Legislature for consideration. The seventh grade school entry requirement for pertussis vaccine (Tdap) will become effective in August 2013. A statewide adolescent immunization campaign is planned during this time period. The Immunization Division will partner with the MCH Bureau for an exhibit at the SC AAP conference in July 2012. The Division will continue to participate on the Birth Outcomes Initiative (BOI) workgroup with a focus of prevention of pertussis in pregnant women and caregivers of newborns and prevention of Perinatal hepatitis B infections.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	25	25	24	24	19
Annual Indicator	27.3	26.8	23.6	20.9	20.9
Numerator	2540	2519	2202	2017	2017
Denominator	93198	94091	93484	96443	96443
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	17	16	15	15

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
The continuation rate for teens under 15 years old for FY 2011 was 96%. The continuation rate for teens 15-17 years old for FY 2011was 94%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote awareness through media campaigns, health fairs, and health care providers with the Teen Pregnancy Prevention Campaign			X	
2. Initiate a youth development project in at least one new county	X			
3. Collaborate with schools and community groups to provide support services in addition to clinical services.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs				X
5. Leverage resources and build partnerships				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SC DHEC received $755,337 for the second year of Personal Responsibility Education Program (PREP) funding. Through RFPs held by the SC Campaign, 13 subgrantees were awarded funding to implement one or two of three evidenced-based programs (Making Proud Choices!, Safer Choices, and What Could You Do?). The subgrantees were trained on the curricula and evaluation process and are currently implementing in 15 counties. The SC Campaign held another bidder's meeting May 16. Applications are due back to the SC Campaign office June 22. Awarded subgrantees will receive initial funding and training in time to begin implementation in Fall 2012.

The SC Campaign to Prevent Teen Pregnancy was awarded the CDC grant called Integrating Services, Programs, and Strategies through Communitywide Initiatives to decrease teen pregnancies in 2012. Through this grant, the Campaign has been working with 6 health department clinics in 2 counties to improve the teen pregnancy rates. The numbers of teen clients receiving Family Planning services in each of the 6 locations has increased and special emphasis has been placed on providing Long Acting Reversible Contraception (LARCs).

c. Plan for the Coming Year
SC DHEC will continue partnering with the SC Campaign to Prevent Teen Pregnancy and the University of South Carolina Arnold School of Public Health in utilizing PREP funds for youth across the state. We plan to work on collaborating with SC Department of Social Services and Department of Juvenile Justice in order to target vulnerable youth in or transitioning out of the foster care and juvenile justice systems. We also plan to enhance the adult preparation subject matter being provided to PREP participants, such as healthy relationships, parent-child communication, adolescent development, and healthy life skills.

SC DHEC will continue the grant activities of the CDC grant in Horry and Spartanburg counties in an effort to continue the decline in teen pregnancy rates in these counties. The Family Planning Program will use the lessons learned from these grant activities in the other 44 counties to continue to decrease statewide unintended pregnancy rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	45	50	50	30	26
Annual Indicator	23.7	23.7	23.7	23.7	23.7
Numerator	629	629	629	629	629
Denominator	2657	2657	2657	2657	2657
Data Source		MCH	MCH	MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26	28	30	33	36

Notes - 2010
Needs Assessment

Notes - 2009
Data are only collected every 5 years. The Division of Oral health will conduct another needs assessment in 2012.

a. Last Year's Accomplishments
In 2011, the South Carolina School Dental Prevention Program was active in 48 school districts, and 384 schools were touched by these programs. Approximately 9,661 children received one or more sealants on permanent molars through this program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Manage DHEC School Dental Prevention Program			X	

2. Collaborate with organized dentists, hygienists and local schools to build partnerships that will secure oral health services for children				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SC DHEC continues its role as coordinator of the School Dental Prevention Program (SDPP) with four public-private partnerships.

c. Plan for the Coming Year
In the coming year, data will be analyzed from public-private partnership submissions to be compared with previous years to look for clusters and trends in the data.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.6	3.5	3.5	3.5	3.1
Annual Indicator	5.3	3.4	3.3	3.1	3.1
Numerator	46	30	30	28	28
Denominator	870430	879360	896740	895440	895440
Data Source		Injury Prev	Injury Prev	Injury Prev	Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.9	2.7	2.5	2.3	2.1

Notes - 2010
2010 data reflect provisional estimates based on 2009 figures.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments

The DHEC Division of Injury and Violence Prevention was funded $1.3 million by the CDC to participate in the National Center for Injury Prevention and Control's Core Violence and Injury Prevention Program (Core VIPP) for 2011-2016. The primary purpose of SC's participation in the Core VIPP is to strengthen and enhance the existing injury prevention program's capacity to achieve the following goals: enhancing injury and violence prevention program infrastructure; collecting and analyzing data; affecting policy change; and effectively evaluating injury prevention programs and policy interventions. The program provides education to and coordination of communities and partners to reduce the occurrence of injury and violence.

Following the passing of Chandler's Law, the All-Terrain Vehicle (ATV) safety bill, DHEC collaborated with several partners such as Safe Kids of SC, The Children's Hospital Collaborative of SC, Medical University of SC, Steve and Pam Saylor (Parents of Chandler), The Children's Trust of SC, Honda, 4-H, and Emergency Medical Services for Children to form a coalition to promote ATV safety. An ATV Safety Communication Plan was developed with key messages and implementation methods to target parents of children allowed to ride ATVs. Some of the strategies were visual representations/flyers, face-to-face communication with parents, distribution of information materials, mass media initiatives, public service announcements (PSAs), and social networking. The coalition created a website, ChandlersATVLaw.com, which consist of information about the law, training, Q & A for children and parents, and scenarios to understand law. Since the debut of website September 1, 2011 until May 15, 2012, there were over 4,000 hits. The website is connected to a Facebook account and has 250 Twitter followers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Create website that consists of ATV safety information and requirements of Chandler's Law			X	
2. Collaborate with community organizations with ATV focus				X
3. Collaborate with the SC Department of Highway Safety and Department of Natural Resources to promote ATV safety and enforce new law				X
4. Develop PSAs, flyers, social media (Facebook and Twitter), and factsheets for public use			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In August 2011 the SC Injury Free Alliance (SCIFA) launched initiatives to address motor vehicle crash issues in SC pertaining to ATV and child passenger safety (CPS). SCIFA will develop, implement, and evaluate systems and environmental change activities within the state. The statewide ATV coalition is developing a 5-year strategic plan to establish goals designed to address identified priorities. The strategic plan addresses data collection, education and implementation, policy, communication and marketing, law enforcement, and sustainability. DHEC created an ATV safety flyer and poster to promote the Chandler's Law requirements and ChandlersATVlaw.com website. Printed material reflects the statewide message "Keep your children safe when riding an ATV: Right Size ATV. Right Gear. Right Training. Everytime!"

In regards to CPS, SCIFA is advocating for a stronger child occupant safety law by increasing age requirements and establishing new height requirements instead of focusing on the weight of a child. The policy plan aims to: strengthen existing CPS legislation; develop and implement

CPS/Booster Seat regulations that incorporate National Highway Safety Administration and AAP standards and best practices; create booster seat usage communications strategy; create and implement community education programs targeting CPS; and create CPS/car booster seat usage data repository to supplement existing child passenger safety data surveillance.

c. Plan for the Coming Year

In the coming year, DHEC and the SC Injury Free Alliance (SCIFA) will start implementing the activities associated with goals developed in the ATV strategic plan and Child Passenger Safety (CPS) policy plan. The workgroups will establish work plans with SMART objectives to execute activities, and the initiatives formed from the activities will be evaluated. Policy and evaluation in-service training is included as part of the policy plan for the CPS booster seat initiative in order to engage key partners in developing and/or implementing injury and violence prevention initiatives. Additionally, organization-specific trainings will be offered to SCIFA member organizations that teach advocacy and education on injury prevention issues. DHEC will conduct a needs assessment among statewide partners to determine if a large, single, or annual policy conference might achieve the greatest benefit.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	61	65	65	42	38
Annual Indicator	37.1	35.3	35.4	35.7	35.7
Numerator	20600	19912	19332	18408	18408
Denominator	55591	56471	54595	51566	51566
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	39	43	47	51	55

Notes - 2010

2010 data reflect provisional estimates based on 2009 figures.

Notes - 2009

2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments

Funding for peer counselors continued to increase through the USDA Loving Support funds. These funds allowed more local clinics to hire peer counselors across the state. Each DHEC public health region has at least one breastfeeding coordinator, who manages the local peer counselor program. All peer counselors and breastfeeding coordinators attend the Annual Peer Counselor Update, which provides current information on promotion, protection and support of breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the breastfeeding peer counselor program		X		
2. Improve accuracy of collecting WIC breastfeeding data				X
3. Provide training to Regional staff about data input, cultural sensitivity, and the use of peer counselors				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Natural Nutrition is a new SCDHEC Initiative for Breastfeeding Promotion. All mothers are counseled on the benefits of breastfeeding for mothers and babies during the WIC prenatal certification. During the week of certification all prenatals will receive a Natural Nutrition packet in the mail. This information will include: a note card from the peer counselor with her office cell phone number; Breastfeeding for the Best Start; A New Mothers' Guide to Breastfeeding in the Hospital; Five Steps to a Good Latch; Breast Milk Expression and Storage; Infant Feeding Plan and Crib Card and a Do Not Disturb Door Hanger. Materials are available in Spanish for the mothers.

The South Carolina WIC Program has scheduled Certified Lactation Counselor (CLC) certification trainings for February and July 2012 for up to five Breastfeeding Coordinators, Nutrition Education Specialists and Registered Dietitians from each region. The goal is to provide a Lactation Expert in each health department throughout the state.

The WIC program has utilized various media outlets to promote breastfeeding. These media sources include magazines, television, and radio.

c. Plan for the Coming Year

A breastfeeding friendly workplace policy for the agency is currently being developed and under review by human resources.

Research is under way to determine the feasibility of the agency partnering with other health care institutions to sponsor CLC trainings throughout the state for staff from hospitals and physician offices.

The Bureau of Maternal and Child Health, Office of Public Health Nutrition, and the Division of WIC are leading the state in developing a strategic plan to increase breastfeeding initiation and duration rates.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100

Annual Indicator	97.9	95.1	96.1	96.6	96.2
Numerator	58573	57431	55633	53682	51779
Denominator	59808	60403	57884	55599	53808
Data Source		MCH	MCH	MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
First Sound completed and launched the Follow Up and Tracking module in the streamlined data system. This module enables the transfer of legacy data housed in a separate data system and integrates any new data collected into the Vital Records-based Birth data Exchange Engine (BEE). This launch also included enhancements to the hospital and audiology data collection modules.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data system development				X
2. Continue PDSA activities as part of NICHQ				X
3. Develop means to collect outcome data for infants diagnosed with hearing loss				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
First Sound continues to work on the data collection system as it begins to develop a means to collect outcome data for infants diagnosed with hearing loss. This will be the final module added to the integrated system. Enhancements to the existing modules will also be included during this phase of development.

First Sound and its extended team of volunteers has been participating in the NICHQ Learning Collaborative this year aimed at reducing lost to follow up for newborn hearing screening. The program has benefited from the collaboration in learning the Plan Do Study Act (PDSA) method of implementation. As a result, the program has piloted several activities that have been successful in other states as well as developing our own activities to trial and share with other

states.

To address access to care, the First Sound program purchased seven Real-Ear Measurement tools for audiology providers to use to accurately fit amplification devices on those diagnosed with hearing loss through the program.

c. Plan for the Coming Year
First Sound will continue to work towards the goal of revising protocols for audiological diagnostics to reflect the minor changes made in the 2007 Joint Commission for Infant Hearing (JCIH) statement once the upcoming amendment is released. First Sound will continue to reach out to programs such as Early Head Start to establish a partnership for guidance and data sharing. First Sound is also scheduled to present the current status and the goals of South Carolina's newborn hearing screening program to providers of the Evidenced-Based Home Visitation program, the Nurse-Family Partnership and other early childhood programs.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8	7	7	9	11.1
Annual Indicator	10.7	12.8	12.8	12.3	14.3
Numerator	112000	137000	137000	137000	153000
Denominator	1042000	1070000	1072000	1112000	1070000
Data Source		ORS	ORS	ORS	ORS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13	12	11	10	9

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
South Carolina continues to struggle with a high unemployment rate compared to the nation. The level of Medicaid services have not changed; however barriers exist to enrolling all eligible children on Medicaid.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Engage partners by participating in quarterly meetings to discuss/ensure Medicaid coverage of low-income children				X
2. Nurture existing partnerships and develop new partnerships to ensure an adequate work force to serve children in a coordinated system of care				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DHEC maintains strong partnerships with pediatricians throughout the state and with DHHS, the state Medicaid agency. The Director's Pediatric Advisory Committee continues to meet and discuss issues that greatly impact access to care for South Carolina's pediatric population.

c. Plan for the Coming Year

DHEC and the MCH Bureau will continue to facilitate Medicaid enrollment whenever possible. As SC DHHS prepares for full implementation of the Affordable Care Act in 2014, it is increasingly important that those children currently eligible for Medicaid be enrolled. SC DHHS is projected to implement "Express Lane Eligibility" in September 2012. This automatically deems eligibility for those children who receive free and reduced lunches and whose families receive SNAP (Supplemental Nutrition Assistance Program) or TANF (Temporary Aid to Needy Families) benefits.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	28	28	28	28	26
Annual Indicator	4.2	29.9	32.5	46.9	48.0
Numerator	35313	28209	34601	33310	34637
Denominator	837910	94496	106543	71091	72124
Data Source		MCH	WIC	WIC	WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	44	40	36	32	28

Notes - 2010

While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
The WIC staff has been evaluating participant acceptance of the food package changes. Understanding the acceptance will better help the WIC program explain to participants the benefits of the new food packaging. Overall, fewer WIC dollars have been utilized, and there is concern that the current economy has created a dilemma for the participants. For this reason, evaluation of the new food packaging is necessary.

South Carolina WIC is currently in the beginning stages of developing a plan to implement the EBT card system. The EBT card will enhance client services by improving access to WIC foods without having to sign WIC checks in the grocery store. WIC clients can select the food items they would like to purchase within a month rather than having to purchase all food items that were written on a WIC check during a shopping trip. EBT will simplify the retail point-of-sale transactions and improve shopping convenience without the stigma of using and signing WIC checks while at the cash register.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Build capacity in the state by focusing on policy and environmental support changes, disseminating best practice information and proving technical assistance				X
2. Increasing availability and access to group nutrition education classes		X		
3. Evaluate participant acceptance of food package changes				X
4. Devise a plan to shift WIC to an EBT system				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Three DHEC public health regions now offer child weight management nutrition education classes at a total of 14 local sites. Class offerings vary from once every 3 months to 2 times per month depending on site size and caseload. Three local Registered Dieticians have acquired certificates in childhood and adolescent weight management from the Academy of Nutrition & Dietetics.

All materials for the Farmers' Market Nutrition Program were updated with a new look in both English and Spanish. This includes: the Authorized Foods sign, voucher holders and posters for Health Department. Five colorful inserts were developed to be placed in the voucher holders. The content of inserts includes recipes and tips on choosing, storing, preparation and nutritional value to be used during certification and facilitated learning sessions

The Farmers' Market Text Pilot Program was implemented in four areas across the state to evaluate if sending a text message each week during the Farmers' Market season will increase voucher redemption rates. One message per week was sent to clients who chose to opt in to the program during the Farmers' Market season. Staff will evaluate the effectiveness of the pilot to determine if the program will be implemented statewide during the 2012 market season.

South Carolina is moving forward with plans on implementing a WIC EBT system. A planning document has been developed for submission to USDA for approval to begin the initial stages of planning and implementation.

c. Plan for the Coming Year
The remaining 5 regions will be encouraged to offer Registered Dietician-facilitated weight management classes. Education materials specific to childhood weight management are planned for development along with an established curriculum.

Next year, WIC will continue to use the media to focus efforts on decreasing overweight and obesity rates among children. The information provided will range from research to running to recipes. New radio spots will be developed targeting the undocumented immigrant population and will address their fear of raids or being reported by the health departments.

The State will continue to move forward with EBT implementation. Workgroups will be formed to include all stakeholders.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10	10	10	10	9
Annual Indicator	9.5	9.6	9.5	9.3	9.3
Numerator	5903	6039	5775	5423	5423
Denominator	62316	63077	60682	58325	58325
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.5	8	7.5	7	7

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
MCH programs providing direct services continued to adhere to the 2As + R policy. This policy gives guidance for staff that interact with tobacco-using clients to "ask" about their tobacco use habits, "advise" them to quit, and "refer" them to SC Tobacco Quitline resources if they are ready to make a quit attempt.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote 2As+R online training to prenatal providers statewide				X
2. Maintain multi-call Quitline services for SC's pregnant population			X	
3. Facilitate Quitline referrals for pregnant tobacco using clients in DHEC clinics			X	
4. Partner with providers and Health Plans to increase pregnant Medicaid utilization of Quitline services through fax referral		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In the current fiscal year, there have been a total of 876 fax referrals from DHEC sites.

The Tobacco Division is partnering with SC DHHS, their Medical Home Networks (MHNs), the Department of Alcohol and Other Drugs Abuse Services, and the Department of Mental Health to implement the federal Patient Protection and Affordable Care Act mandate that the State's Medicaid program comply with Title IV, Subtitle B, Sec. 4107 -- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid. This program, entitled SBIRT (Screening, Brief Intervention, Referral and Treatment) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The target population is Medicaid members who are pregnant, and the focus is on tobacco, substance use disorders, depression, and domestic violence. Tobacco Division staff provide guidance and technical assistance to all seven Medicaid Health Plans -- the MHNs and Managed Care Organizations (MCO) -- and their providers on the SBIRT component to address tobacco cessation intervention through the SC Tobacco Quitline. The ultimate outcome of the project is to capture and track data on the pregnant members referred to the Quitline by Medicaid providers through the SBIRT initiative and determine the level of services received, hopefully leading to a successful quit attempt.

c. Plan for the Coming Year
The Division will continue to expand its efforts in the SBIRT initiative, eventually working towards the possibility of Medicaid reimbursement for clients served by the SC Tobacco Quitline.

Additionally, resulting from the work of the Birth Outcomes Initiative, SC DHHS will implement incentives for Medical Home Networks and Managed Care Organizations that improve compliance with the SBIRT initiative through consistent screenings and necessary brief interventions.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011

Data					
Annual Performance Objective	6	6	5.5	3	7
Annual Indicator	3.8	9.7	7.2	7.0	7.0
Numerator	12	31	23	23	23
Denominator	318280	321140	321260	328990	328990
Data Source		Injury Prev	Injury Prev	Injury Prev	Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6.8	6.5	6.2	6	6

Notes - 2010
2010 data reflect provisional estimates based on 2009 figures.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
The DHEC Division of Injury and Violence Prevention will continue to support the SC Injury Free Alliance (SCIFA), the SC State Child Fatality Advisory Committee (SCFAC) and the Suicide Prevention Coalition to fulfill its mission to reduce youth violence and suicide. SC SCFAC has produced a draft of the 2007 -- 2008 Annual Report which captures data, resources, and recommendations related to youth suicides. Dissemination of the Suicide Prevention brochure occurred and was distributed to stakeholders and partners. MCH staff actively participate in SCIFA SCFAC, and the Suicide Prevention Coalition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue participation on the SC Suicide Prevention Coalition				X
2. Continue participation on the SC Injury Free Alliance				X
3. Conduct a data dissemination workshop to include data related to violent deaths				X
4. Continue participation on the SC State Child Fatality Advisory Committee and promote policy change				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
South Carolina Violent Death Reporting System continues to provide comprehensive details of circumstances of violent deaths. The Division of Injury and Violence Prevention also maintains an

injury surveillance system to determine the magnitude, causes, and risk factors associated with injury and violence related deaths.

c. Plan for the Coming Year
The Division of Injury and Violence Prevention (DIVP) will continue to provide surveillance on intentional injuries and deaths for South Carolinians and youth. Evidence based programs and strategies will be promoted in order to address injury and violence prevention by targeting specific areas such as youth violence and intentional injuries, including suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	84	84	86	75	80
Annual Indicator	71.9	73.9	78.1	78.6	78.6
Numerator	931	873	822	807	807
Denominator	1294	1181	1053	1027	1027
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	82	84	86	86

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
Perinatal Regionalization has made continued progress in 2011. Regional Perinatal Centers continue to provide services to high risk obstetric patients and extremely sick infants. All Regional Centers maintained an Outreach Staff that provided consultation, education, and technical assistance throughout the State.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Perform outreach education to regional and rural hospitals, health departments, and community agencies				X
2. Review all VLBW deliveries that occur outside of a Regional				X

Perinatal Center (level III)				
3. Participate in Fetal and Infant Mortality Review meetings throughout the state and at the state level				X
4. Collaborate with the SC DHHS Birth Outcomes Initiative				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Regional Systems Developers continue to conduct an annual assessment of their respective Perinatal Region. Objectives of the current assessment involve continuing to provide outreach education, consultation to rural hospitals, and continued monitoring of the perinatal system.

Regional Perinatal Staff are heavily involved with the Birth Outcomes Initiative (BOI) that was initiated by SC DHHS in response to a movement to decrease Neonatal Intensive Care Units length of stay. The BOI has brought various stakeholders together in an effort to reduce preterm birth in SC. The Regional Perinatal Staff has become a central component of the effort.

One major success of the BOI was to bring representatives from each of the 43 birthing hospitals to a Birth Outcomes Summit. The BOI Summit educated hospital professionals on reducing elective inductions prior to 39 weeks.

c. Plan for the Coming Year
In the coming year, the MCH Bureau will continue to devise and execute collaborative strategies to positively impact birth outcomes in the state. Prematurity prevention and infant mortality reduction remain a priority.

A contract is being developed between MCH Bureau and South Carolina Hospital Association, March of Dimes, and DHHS to work together on perinatal quality initiative for the next three years. Continued work on the Birth Outcomes Initiative is also being completed.

In addition to this work, Regional Perinatal Staff will continue reviewing SC's perinatal regulations. These regulations are being revised in 2012-2013. The Neonatal Consortium and Maternal Fetal Medicine physicians, March of Dimes, and all major hospitals are currently working on efforts to ensure SC's regulations are updated but maintain the integrity of our regionalization program and hospital referral patterns.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	76	80	90	75	75
Annual Indicator	68.6	69.0	70.3	72.1	72.1
Numerator	43159	43512	42675	42039	42039
Denominator	62933	63077	60682	58325	58325
Data Source		Vital Records	Vital Records	Vital Records	Vital Records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	77

Notes - 2010
While 2010 data are porvisional they are not merely a reflection of the 2009 data.

Notes - 2009
2009 Birth File not available

a. Last Year's Accomplishments
Work with Medicaid and Managed Care Organizations continued in order to improve access to and early entry into prenatal care. The Commissioner's OB Task Force continued to address issues that inhibit early and adequate prenatal care.

Additionally, the Prenatal Care Quality Improvement initiative ended. DHEC Health Services was one of 16 states selected to participate in a national initiative called the Multi-state Learning Collaborative 3 to advance accreditation efforts and quality improvement strategies in public health departments. This initiative was funded by the Robert Wood Johnson Foundation. The long-term goal of the SC Collaborative was to increase the number of pregnant women who receive early and adequate prenatal care. The SC Collaborative consisted of five teams, one from Central Office and five from the health regions. The teams used the Plan/Do/Study/Act (PDSA) Cycle to implement change in clinic operations. The SC Collaborative identified methods to improve patients prenatal care referrals, prenatal care service delivery, and prenatal care data collection. Two promising practices based on improving prenatal care in WIC and FP clinics emerged: 1) For clients who test positive for pregnancy in the FP clinic, FP administrative staff should schedule a WIC appointment at the time of check out; 2) Three-day reminder calls for WIC appointments should be conducted.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refer patients with positive pregnancy tests to prenatal care providers, and execute appropriate follow-up to ensure early entry into care	X			
2. Educate pregnant women with the Caring for Tomorrow's Children book		X		
3. Leverage resources and build partnerships				X
4. Participate on the Commissioner’s OB Task Force to identify prenatal care access issues and develop appropriate solutions				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The five teams that participated in the Robert Wood Johnson Foundation multi-state learning collaborative continue to implement the positive changes that resulted from the collaborative. Additionally, the Together for Beaufort Coalition, headquartered in Beaufort County, continues to make progress towards improving data quality of prenatal care initiation date reporting for birth statistics purposes.

c. Plan for the Coming Year
DHEC Family Planning and WIC clinics will continue to refer women to prenatal care providers. The MCH Bureau will also continue to play a critical role in the Director's Obstetric Task Force, which serves as a forum to identify and discuss issues affecting pregnant women and infants in South Carolina.

The MCH Bureau will also continue to promote the Text4Baby campaign, which provides targeted messages for pregnant women via text messaging. This campaign will encourage women to encourage pregnant women to enter prenatal care as soon as possible.

D. State Performance Measures

State Performance Measure 1: *Increase the number of perinatal regions with an established pre/inter-conception health coalition working to identify and address pre/interconception health needs of women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					3
Annual Indicator				2	1
Numerator				2	1
Denominator				5	5
Data Source				Self Assess	Self Assess
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	3	3	3	3

a. Last Year's Accomplishments
A Preconception Health Coalition (PHC) meeting was held in November 2010. The DHEC Office of Public Health Statistics and Information Systems provided data for each of the Perinatal Regions at the initial coalition meetings using preconception health indicators defined by the Council of State and Territorial Epidemiologists. The data presentation included information on various indicators including: insurance coverage, pregnancy intendedness, prepregnancy and postpartum contraception use, smoking alcohol use, multivitamin use, inter-pregnancy interval, BMI before pregnancy, and chronic illness. Each regional PHC was presented with indicators for which their prevalence or trend outcomes were less favorable than other areas of the state. Additionally, the attendees of each regional PHC meeting had the opportunity to share information and ideas about their respective programs and learn about preconception health data specific to the region in which they serve clients.

One outcome of the initial meetings was that region level DHEC staff expressed an interest in

providing preconception health services to women seen in family planning clinics.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain and develop partnerships with stakeholders in the public and private sector related to preconception health				X
2. Conduct regional PHC meetings quarterly				X
3. Conduct an assessment of preconception health programs in the state				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Unfortunately in 2011, efforts continue development of the Preconception Health Coalitions were dissolved. Funding for the initiative was originally provided by the SC Chapter of the March of Dimes; however, they recently revised the process for grant awards. However, preconception health education remains a priority of the MCH Bureau. Reproductive life planning books, developed by a Perinatal Regional Center and the March of Dimes, were distributed to every Family Planning site in the State. Health department nurses were also trained on how to incorporate reproductive life planning questions into patient assessments.

c. Plan for the Coming Year

South Carolina is still dedicated to participating in Every Woman South East and developing Every Woman South Carolina. The University of North Carolina has received a Kellogg's Foundation grant to bring the Southeastern states together again and hopefully provide pilot grants to states for preconception health programming. The MCH Bureau Perinatal Manager is a co-chair for this effort.

Although previous resources for the Preconception Health Coalitions are no longer available, the MCH Bureau is evaluating partnerships to facilitate moving forward with the coalitions, perhaps in a different format. Partner organizations will be more heavily relied upon to ensure success of these coalitions.

State Performance Measure 2: *Reduce the percent of combined infant deaths due to SIDS and accidents due to unsafe sleeping environments*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1
Annual Indicator		1.5	1.1	1.3	1.3
Numerator		94	66	74	74
Denominator		63077	60682	58325	58325
Data Source		Vital	Vital	Vital	Vital

		Records	Records	Records	Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0.9	0.8	0.8	0.8	0.8

Notes - 2010
2010 data reflect provisional estimates based on 2009 figures.

a. Last Year's Accomplishments
The Emergency Medical Services for Children (EMSC) Program partnered with the MCH Bureau to revise and reprint the Safe Sleep training tools originally created in 2008. These training tools continue to be used by many community partners and safe sleep advocates. These materials are available in Spanish, and they also have a section devoted to addressing culturally driven behaviors.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop Public Awareness Campaigns			X	
2. Conduct educational workshops for daycare providers				X
3. Collaborate with community partners to disseminate the safe sleep message			X	
4. Participate in Infant Mortality Review to study trends in infant sleep related deaths				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MCH Bureau is actively involved in the SC Safe Sleep Coalition, led by the Children's Trust of South Carolina. The Coalition is in the process of developing a report for the Joint Citizens and Legislative Committee on Children, which identified Safe Sleep as one of four priority areas for the health and well-being of the children in South Carolina. The SC Safe Sleep Coalition is focusing on policy, data and reporting, education, and marketing.

c. Plan for the Coming Year
The MCH Bureau will continue to play an active role in the SC Safe Sleep Coalition, specifically activities related to education, data and reporting. MCH staff will also continue to provide education throughout the state via presentations, print materials, dvds, and other exhibits.

State Performance Measure 3: *Increase the percent of early childhood service providers trained in social/emotional development using an established evidence based curriculum*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					50
Annual Indicator				32.2	41.0
Numerator				103	1721

Denominator				320	4200
Data Source				MCH	MCH
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	50	50	50

Notes - 2011
Numerator combines providers trained in 2010 and 2011 since the denominator reflects the total goal of providers trained by 2014.

This performance measure originally included parents; however, training has been targeted towards providers, and providers are the only audience captured in the data. In the second year of implementation, efforts far exceeded expectations; therefore, the denominator has been increased for 2011 and coming years.

a. Last Year's Accomplishments
The Early Childhood Comprehensive Systems (ECCS) grant contracted with the SC Department of Social Services, Child Care Division to fund a Center for the Social Emotional Foundations of Early Learning train-the-trainer event (CSEFEL: Positive Solutions for Families) that was tailored for staff working with families. The Maternal, Infant, Early Childhood Home Visitation Grant (MIECHV) led by the Children's Trust of SC was a key partner and funder for this project. Participants enrolled in this March 2012 training were from each of the home visitation models in the state as well as child care Technical Assistance providers who were certified in the 2010 CSEFEL trainers training. Adding to the 2010-11 cohort of 40 trainers, twenty-five people were in the 2011 -2012 trainer cohort. The 2011 CSEFEL trainers provided CSEFEL training primarily to child care and mental health providers, effecting a total count of 1618 people. This figure far exceeds our original training goal of 320 early childhood staff. The CSEFEL curriculum has been very popular in the early childhood field and the SC State Department of Education organized additional train-the-trainer opportunities. For this reason, we have modified the denominator for this performance measure for the coming years.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide professional development across early childhood disciplines in Social Emotional curriculum				X
2. Collaborate with state and community agencies to ensure the CSEFEL training is provided throughout the state				X
3. Monitor the expansion of CSEFEL trainings				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The ECCS and MIECHV funded training of trainers in CSEFEL took place in March of 2012. Dr. Clement-Atkinson provided the/parent focused CSEFEL training called Positive Solutions for Families. This 2011-2012 cohort of 25 trainers have now begun to provide trainings across the state.

The trainings are delivered in settings amenable to people with differing needs and abilities, and

the need for accommodations is addressed in the enrollment process. There is at least one trainer who can provide trainings for Spanish speaking participants. The print materials from CSEFEL are also available online in Spanish.

c. Plan for the Coming Year
ECCS funds are available to contract another cohort of trainers during 2012-2013. ECCS leadership team members from child care, parenting, and family support areas will review the training data collected at the Center of Child Care Career Development. The two cohorts of certified CSEFEL trainers have rapidly expanded the work force trained in CSEFEL. Attrition of trainers and demand for ongoing training of existing and new staff will be considered to determine future CSEFEL training needs for the state.

State Performance Measure 4: *Increase the number of parents or caregivers participating in the planning, implementation, and evaluation of DHEC programs and services for children with special needs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					0.1
Annual Indicator				0.0	0.0
Numerator				0	0
Denominator				10	10
Data Source				CSHCN	CSHCN
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0.1	0.2	0.2	0.3	0.3

a. Last Year's Accomplishments
All recommendations for policy changes are sent to Family Connection for review during development. The priorities for last year were assuring documentation of guidelines for current activities. Systematic review of new policies and processes will be undertaken during upcoming year. Communication with Family Connection has been strengthened during the last year to assure input from families to DHEC and from DHEC to families. Hiring restrictions have prevented addition of paid parent or staff member dedicated to parent involvement. Alternative uses of Family Connection resources are being explored.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Engage families of CSHCN in program policy and procedure development				X
2. Continue partnership with Family Connection				X
3. Establish a CSHCN Advisory Committee with representation from CSHCN families				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In October 2011, DHEC convened a meeting of representatives of key statewide family support organizations to discuss families' perspectives on current DHEC services, effective advisory committee recommendations, and their current priorities for their agencies. This information was used as a foundation for subsequent planning discussions which resulted in development of a comprehensive plan for use of Title V resources to increase access to family support services, create a system for obtaining family input and feedback on CSHCN services. Agency review and approval is in progress.

c. Plan for the Coming Year
In the coming year, DHEC will use available resources to enhance parent involvement activities; identify DHEC staff members statewide with CSHCN who are willing to provide email feedback to the Division of CSHCN one to three times per year in order to help guide program planning activities; incorporate guidance for routine inclusion of family input into care plan development and service delivery; identify a family leader to represent SC at the annual AMCHP meeting; and identify a staff member responsible for coordination of parent involvement activities. In addition, Title V Block Grant application information specific to CSHCN will be prepared in time to assure family input before July application submission.

State Performance Measure 5: *Increase the percent of public health regions who plan, implement, and evaluate programs at least one optional program in each of four established MCH population groups*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					8
Annual Indicator				0.0	71.9
Numerator				0	23
Denominator				32	32
Data Source				MCH	MCH
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	81.3	90.6	100	100	100

a. Last Year's Accomplishments
DHEC implemented the Living Within Our Means (LWOM) initiative in an effort to examine current programs and assure best use of funds. As part of this process, the MCH Bureau analyzed distribution of funds and prioritized current programs. This process functioned as the first step in regional planning for the four established MCH populations. The outcome of the LWOM process was a three-tier system of program prioritization. Tier 1 programs are deemed mandatory. All other programs are considered optional and can be used in the MCH plans for the public health region. Although the regions have not yet started their plans, this year has been used to develop a framework for creating the MCH plans.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to the public health regions for MCH plan development, implementation, and evaluation				X
2. Share region MCH plans with key central office staff				X

3. Disseminate region MCH plan evaluation results with agency leadership and key central office staff				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In February through April 2012, staff worked diligently to conduct MCH Site Visits to each of the eight DHEC public health regions. The Women and Children's Services Division Director, MCH Epidemiologist, and MCH Planning and Evaluation Coordinator visited each region with information related to data, budgets, and program planning and evaluation. Each region was tasked with developing a detailed plan for each of four identified MCH population groups. The MCH population groups are: pregnant women and infants, women of reproductive age, children and adolescents, and CSHCN. Each plan will consist of a goal, objective, data, rationale, strategies, and performance measures.

When conducting the site visits, several existing, unique initiatives were mentioned by region staff. Unfortunately, many of the initiatives had no formal evaluation plan in place that would demonstrate success. The staff was encouraged to use these existing initiatives for their MCH Plans, and to take advantage of the technical assistance provided by MCH Central Office staff related to planning and evaluation. The regions are in the process of submitting their MCH plan proposals. The MCH Planning and Evaluation Coordinator is serving as the liaison for region staff and central office staff for the plans.

c. Plan for the Coming Year
In the coming year, the region MCH Plans will be reviewed by MCH Central Office leadership, and upon approval, the regions will be able to implement the plans and evaluation processes.

To date, not all regions have developed a plan for each of the four required MCH population groups. Therefore, in the coming year, the MCH Planning and Evaluation Coordinator will target technical assistance efforts to those lacking an MCH Plan. Technical assistance will be provided in the areas of program planning, evaluation, and data collection and dissemination.

State Performance Measure 6: *Increase regional satisfaction with the quality of technical support provided by central office MCH*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					3
Annual Indicator				0	3
Numerator				0	3
Denominator				5	5
Data Source				MCH	MCH
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4	5	5	5	5

Notes - 2011

The actual indicator value is 3.43.

a. Last Year's Accomplishments
The satisfaction survey had not yet been developed; however, the MCH Bureau Research and Planning Unit had internal discussions about various methods to conduct the satisfaction survey with region staff. It has been determined that the best time to administer the survey will be prior to the annual site visit to each region.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop survey to assess technical support satisfaction				X
2. Conduct site visits to regions to discuss survey results				X
3. Devise plan to improve technical assistance offered by central office staff to regional personnel				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In January 2012, the MCH Bureau sent a Technical Assistance Survey to each of the DHEC public health regions via email. The survey assessed the region staff's satisfaction with the technical assistance that MCH Central Office staff provides to them in the areas of: policy change, communication, continuing education, data, education materials, and program operations. The survey also assessed satisfaction with individual programs as well. The region staff's overall satisfaction with MCH Central Office technical assistance rated as 3.43 on a 5-point scale.

One area for improvement was continuing education. There seemed to be a desire for more frequent professional development opportunities that were both financially and geographically accessible. Region staff also expressed interest in providing more input on MCH educational materials that are distributed to health department clients. Currently some programs provide this opportunity; however, there may be a need to make the practice more consistent among all MCH programs. Other potential areas for improved technical assistance include grant writing, implementation of new and revised policies, and program evaluation.

The results of the survey were reviewed with region staff at the MCH Site Visits, which were conducted in February through April 2012.

c. Plan for the Coming Year
In the coming year, the MCH Bureau will develop a plan to address the issues identified with the inaugural MCH Technical Assistance Survey. Efforts will be made to improve in various areas. The survey will be conducted again in January 2013 to assess progress.

State Performance Measure 7: *Increase the number of epidemiological reports completed, distributed, and available to agency leadership/partners*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					2
Annual Indicator				0	4
Numerator				0	4
Denominator				4	4
Data Source				Self Assess	Self Assess
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4	4	4	4	4

a. Last Year's Accomplishments

In the previous year the South Carolina MCH Bureau has produce four fact sheets/issue briefs focusing on the following topics: late preterm birth, infant mortality in 2009, cesarean delivery and mother-reported reasons for cesarean delivery, and influenza vaccination during pregnancy. Furthermore, the MCH Bureau has produced one academic poster focusing on the underreporting of Down syndrome on South Carolina birth certificates as well as a comprehensive Mother and Child Health Data Book focusing on several aspects of infant and child health, maternal lifestyles and health, Title X Family Planning activities, WIC activities, and Postpartum Newborn Home Visits. Data sources for these projects include birth certificates, death certificates, birth defects surveillance program, and PRAMS. All of these were published and distributed in hard copy and also posted on the MCH Bureau website.

Materials published by the MCH Bureau are distributed through several mechanisms. Electronic and hard copies are distributed to physicians and staff in the state's birthing hospitals through the perinatal regionalization network. Furthermore, hard copies of publications are distributed at meetings of the Agency Director's Pediatric Advisory Council and Obstetric Task Force meetings as well as at meetings of the SC Birth Outcomes Initiative. Electronic and hard copies are also distributed to partners such as the SC Chapter of the March of Dimes and the SC Campaign to Prevent Teen Pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Develop a data analysis plan for MCH indicators				X
2. Create and distribute epidemiological reports				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, the MCH Bureau is drafting a fact sheet focusing on South Carolina infant mortality in 2010. The MCH Epidemiologist is also continuing work on the assessment of the potential impact of the Nurse-Family Partnership program in SC. This process has required some creative strategizing, and the data files relevant for this project are currently being linked. Furthermore, the MCH Epidemiologist is supervising three graduate student projects that will result in deliverables to be distributed by the MCH Bureau. These include a databook examining infant mortality through a Perinatal Periods of Risk (PPOR) framework by geographic regions, a comprehensive report on factors associated with breastfeeding using birth certificate, PRAMS,

and WIC data, and an evaluation of a teen-friendly family planning clinic model that was opened in 2009.

c. Plan for the Coming Year
The SC MCH Bureau will publish and distribute the reports described in the Current Activities section along with an updated mother and child health data book, a PRAMS data book, and at least one additional fact sheet. The SC Birth Defects Program has also modified its data system to capture the use of pulse oximetry screening to aid in identification of critical congenital heart defects. This information will be used for assessment and program planning activities.

State Performance Measure 8: *Increase the percent of national performance measures with a formal improvement plan that includes measurable goals, objectives, and benchmarks to evaluate progress towards improvement.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					5
Annual Indicator				0.0	22.2
Numerator				0	4
Denominator				18	18
Data Source				MCH	MCH
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	44.4	66.6	83.3	100	100

a. Last Year's Accomplishments
No formal activity for this performance measure was done last year because the focus of the Bureau was on preparing for Living Within Our Means.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify process objectives for national performance measures				X
2. Incorporate improvement plans into regional MCH plans				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently, the MCH Bureau is assessing the number of national performance measures that have an existing evaluation plan. To date, only four evaluation plans have been identified. This provides a significant opportunity for improvement.

c. Plan for the Coming Year

Now that the initial assessment has been completed, the MCH Planning and Evaluation Coordinator will meet with key division directors and program staff to: 1) discuss progress with the national performance measures, 2) determine what improvements are feasible and 3) identify process objectives that can be used in developing a formal evaluation plan.

Additionally, the MCH Bureau will conduct a data capacity assessment among MCH Central Office program managers and coordinators to determine staff ability in regards to program planning, evaluation, data dissemination, etc. The data capacity assessment will serve as a needs assessment for a workshop that will be conducted for MCH staff to build infrastructure and skills related to data usage, reporting, and dissemination.

State Performance Measure 9: *Reduce the annual rate of maternal deaths*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					2.5
Annual Indicator		3.2	3.0	2.4	2.4
Numerator		20	18	14	14
Denominator		63077	60682	58325	58325
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2011
2011 data reflect provisional estimates based on 2010 figures. The SCHIP Stand alone program no longer exists in SC.

Notes - 2010
2010 data are updated and final.

a. Last Year's Accomplishments
MCH Bureau staff met with an Obstetrician regarding the current maternal mortality review process and the potential for improvement. Following the meeting, MCH Bureau staff met with the DHEC Public Health Statistics and Information Systems (PHSIS) department on how to proceed with a formal maternal mortality review. Continued discussion with stakeholders regarding the proposed review process occurs.

Additionally, due to the danger and possible death associated with the flu in pregnant women, the Maternal Fetal Medicine (MFM) Collaborative met with the assistance of the Regional Systems Developers and planned a coordinated statewide protocol to address the flu in pregnancy women. A standardized protocol was developed and disseminated to all obstetric providers from the MFM Collaborate outlining that the flu vaccine was to be given to all pregnant women and their family members. In addition, a treatment algorithm was written to address what medications were to be given to pregnant women who had been exposed to the flu while pregnant. The MFM Collaborative also worked closely with the Immunization Division at DHEC to ensure the flu vaccine was directed to the appropriate medical facilities for dissemination.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Continue efforts to promote flu vaccination of pregnant women	X			
2. Develop a formal maternal mortality review process at the state level				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Key MCH Bureau staff met with an Obstetrician and DHEC Legal Staff to discuss the implications of initiating a Maternal Mortality Review. Next steps for moving forward are being identified.

Additionally, as part of the SC Infant Mortality Reduction Plan that resulted from the HRSA Regions IV and VI Infant Mortality Summit, increase access to flu vaccine for pregnant women has been identified as a priority.

c. Plan for the Coming Year
In the coming year, the MCH Bureau will continue to work towards implementation of a formal maternal mortality review process.

Additionally, the MCH Bureau will collaborate with the Division of Immunizations to promote availability of flu vaccine in provider offices, specifically for pregnant women.

E. Health Status Indicators

The outlined health status indicators are somewhat helpful in directing public health efforts. Some measures are more relevant to Title V programming than others. Certainly measures related to birth weight, unintentional injury/motor vehicle crashes, and sexually transmitted disease are relevant for directing public health efforts and should be included as part of routine surveillance activities. In South Carolina these tend to fall outside the direct leadership of Title V; therefore, are more indirectly related to ongoing program operations. Population demographics can be helpful to a degree but are really used more for background information and are not really appropriate as evaluation measures.

/2013/ Health Status Indicator 1A:
The low birth weight prevalence in South Carolina has been steady from 2007 (10.2%) through 2010 (9.9%). MCH is heavily involved in the South Carolina Birth Outcomes Initiative (BOI), partnering with other state agencies and non-profit groups with a primary goal of reducing the prevalence of low birth weight deliveries in the state. Some initial objectives of the BOI are to reduce inductions and cesarean deliveries in delivering hospitals before 39 completed weeks of gestation if no medical indication is present and to streamline the process for obtaining and reimbursing for 17P. The SC Healthy Mothers, Healthy Babies Infant Mortality Reduction Plan provides a structural framework to support the BOI's efforts.

Health Status Indicator 1B:

Like the rate of overall low birth weight, the prevalence of low birth weight among singleton births has been steady from 2007 (8.3%) through 2010 (8.1%). MCH is heavily involved in the South Carolina Birth Outcomes Initiative (BOI), partnering with other state agencies and non-profit groups with a primary goal of reducing the prevalence of low birth weight in the state. Some initial objectives of the BOI are to reduce inductions and cesarean deliveries in state hospitals before 39 completed weeks of gestation if no medical indication is present and to streamline the process for obtaining and reimbursing 17P.

Health Status Indicator 2A:
The percent of very low birth weight deliveries has remained steady from 2007 (2.1%) to 2010 (1.9%) in South Carolina. MCH is heavily involved in the South Carolina Birth Outcomes Initiative (BOI), partnering with other state agencies and non-profit groups with a primary goal of reducing the prevalence of low birth weight in the state. While there is reason to believe that these efforts will move some infants from being born low birth weight to being normal birth weight, they could also move some infants from being very low birth weight to being born low birth weight.

Health Status Indicator 2B:
The percent of very low birth weight deliveries among singleton births has remained steady from 2007 (1.7%) to 2010 (1.6%) in South Carolina. MCH is heavily involved in the South Carolina Birth Outcomes Initiative (BOI), partnering with other state agencies and non-profit groups with a primary goal of reducing the prevalence of low birth weight in the state. While there is reason to believe that these efforts will move some infants from being born low birth weight to being normal births weight, they could also move some infants from being very low birth weight to being born low birth weight.

Health Status Indicator 3A:
The death rate of children aged 14 years and younger due to unintentional injuries has steadily decreased from 2007 to 2010. The DHEC Division of Injury and Violence Prevention's Core Violence and Injury Prevention Program (Core VIPP) aims to develop, implement, and evaluate injury prevention activities pertaining to: Concussion in Youth Sports; Child Passenger Safety (CPS) -booster seat use; Unintentional Poisoning; Intimate Partner Violence; and All-Terrain Vehicle (ATV) safety. The two policy strategies of the program pertain to concussion in youth sports and booster seat use. The MCH Bureau is actively involved in these injury prevention activities.

Health Status Indicator 3B:
Currently the SC Injury Free Alliance (SCIFA) has developed two subcommittees that are addressing motor vehicle crash issues in SC pertaining to ATV and Child Passenger Safety (CPS) for children age 0-16. The committees were established to develop, implement, and evaluate systems change activities within the state. The CPS subcommittee is advocating for a stronger child occupant safety law by increasing age requirements and establishing new height requirements instead of focusing on the weight of a child. The ATV subcommittee is promoting education and awareness of ATV safety and requirements of the new Chandler's Law for children 16 years and younger.

Health Status Indicator 3C:
The death rate of youth aged 15 through 24 years due to motor vehicle crashes continues to decline. The DHEC Division of Injury and Violence Prevention (DIVP) will continue to work with the SC Dept. of Highway Safety and National Safety Council SC Chapter to educate SC on best practice and policy recommendations to decrease death rates. DIVP continues to provide death and hospital injury data to entities interested in improving the current graduated driving license (GDL) law by lowering the passenger restriction within intermediate phase and adding no cell phone or texting while driving component.

Health Status Indicator 4A:
The rate of nonfatal injuries among children 14 and younger continues to increase. To decrease unintentional, or accidental, injury hospitalizations and emergency department visits among the pediatric population, DHEC Division of Injury and Violence Prevention's Core Violence and Injury Prevention Program (Core VIPP) is implementing policy and systems changes related to: Concussion in Youth Sports; Child Passenger Safety booster seat use; Unintentional Poisoning; Intimate Partner Violence; and All-Terrain Vehicle safety.

Health Status Indicator 4B:
The rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has increased steadily since 2008. DHEC continues to provide Child Passenger Safety (CPS) education and promote booster seat use for the vulnerable age group, 6-10 years old. The South Carolina Injury Free Alliance's CPS subcommittee is advocating for a stronger child occupant safety law by increasing age requirements and establishing new height requirements instead of focusing on the weight of a child. The ATV subcommittee is promoting education and awareness of ATV safety and requirements of Chandler's Law for children 16 years and younger. DHEC, along with other state partners, will promote ATV hands-on training, helmet use, and operating or riding the appropriate size ATV.

Health Status Indicator 4C:
The rate of nonfatal injuries due to motor vehicle crashes among 15 to 24 year olds has steadily declined since 2007. The DHEC Division of Injury and Violence Prevention continues to work with the SC Dept. of Highway Safety and National Safety Council SC Chapter to educate SC on best practice and policy recommendations to decrease death rates. DHEC continues to provide death and hospital injury-related data to entities interested in improving the current graduated driving license (GDL) law by lowering the passenger restriction within intermediate phase and adding no cell phone or texting while driving component.

Health Status Indicator 5A:
Data indicate that the rate of Chlamydia among women 15-19 has decreased since 2009.

Health Status Indicator 5B:
Data indicate that the rate of Chlamydia among women 20-44 has increased since 2009.

Health Status Indicator 6A:
There was a slight increase in the total population of children aged 0-24 years from 2010 to 2011. This increase was mostly due to increases in those aged 20-24 among white, black/African American, and multiple race populations.

Health Status Indicator 6B:
There was a substantial increase in the population of children aged 0-24 years with Hispanic ethnicity from 30,674 in 2010 to 85,597 in 2011 (though the 2011 data remains provisional). There were increases reported in the number of children of Hispanic ethnicity among every age group. MCH is continuing to partner with the South Carolina PASOs (Perinatal Awareness for Successful Outcomes) program, which provides education and services targeted to the state's Hispanic population. In March 2011 South Carolina PASOs was named a Promising Practice by the Association of Maternal and Child Health Programs.

Health Status Indicator 7A:
The number of live births continued to decrease in South Carolina, dropping from 60,679 births in 2009 to 58,320 births in 2010. The only group that saw a substantial increase in births from 2009 to 2010 was white women <15 years of age (26 births in 2009 compared to

55 in 2010). Overall, there was a 3.9% decrease in births among white women and a 4.3% decrease in births among African American women from 2009 to 2010.

Over the past year, MCH has funded evidence-based curricula aimed to prevent unintended pregnancy and sexually transmitted infections among youths from 10-19 years of age through the Personal Responsibility Education Program (PREP).

Health Status Indicator 7B:
Overall there was a 9.4% decrease in the number of live births to women of Hispanic ethnicity from 2009 to 2010 in South Carolina. There were decreases in Hispanic births among every age group except for Hispanic women 38 or older, which saw an increase from 541 births in 2009 to 588 births in 2010.

Over the past year, MCH has funded evidence-based curricula aimed to prevent unintended pregnancy and sexually transmitted infections among youths from 10-19 years of age through the Personal Responsibility Education Program (PREP).

Health Status Indicator 8A:
The overall number of deaths among infants and children continued to decline, dropping from 1,177 deaths in 2009 to 1,120 deaths in 2010. The number of deaths decreased from 2009 to 2010 by 1.7% among white infants and children and by 7.5% among African American infants and children.

Health Status Indicator 8B:
Overall, the number of deaths to Hispanic infants and children decreased from 2009 to 2010 by 9.0%.

Health Status Indicator 11:
The percent of South Carolinians living below or near poverty increased meaningfully in South Carolina from 2010 to 2011. Those below 50% of poverty increased from 5.5% to 7.2%. Those below 100% of poverty increased from 13.8% to 17.0%, and those living below 200% of poverty increased from 34.6% to 37.4%. This increase in poverty has major implications for the number of individuals eligible for MCH services such as WIC and Family Planning, especially because the total population living in South Carolina continues to increase.

Health Status Indicator 12:
Though the population of South Carolinians from 0 to 19 years of age decreased slightly from 2010 to 2011, the percent of these children living below or near poverty increased. In 2011 over one quarter of South Carolina children from 0 to 19 years of age lived below the federal poverty level, while nearly half lived below 200% of poverty. The percent of children living below 50% of poverty increased from 7.0% in 2010 to 10.2% in 2011, the percent living below 100% of poverty increased from 17.6% to 25.4%, and the percent living below 200% of poverty increased from 40.7% to 46.5%.

This increase in poverty has major implications for the number of individuals eligible for MCH services such as WIC and Family Planning, especially because the total population living in South Carolina continues to increase. //2013//

F. Other Program Activities

South Carolina has been fortunate to receive an environmental public health tracking grant (EPHT) from the Center's for Disease Control and Prevention (CDC). This grant is designed to provide policy makers and the general public integrated public health and environmental data. Two specific areas of MCH will be incorporated into the grant and includes Birth Defects

Surveillance and Lead Surveillance data. This will allow MCH to expand the avenues in which we make surveillance data available to the public and improve data integration with other public health and environmental programs.

/2012/ The MCH Bureau continues to utilize SSDI funding to strengthen the infrastructure of MCH programs by facilitating program data collection and analysis as well as evaluation. Funds are being used for the planned expansion of the Birth Exchange Engine (BEE) with FIMR and Maternal Mortality Review data. The BEE currently houses birth defects surveillance and First Sound data. SSDI funds continue to support data sharing efforts within DHEC as well as outside of the agency. //2012//

/2013/ Funds generated through the State Systems Development Initiative (SSDI) Grant program have enabled the South Carolina Department of Health and Environmental Control (SC DHEC) to progress in data advancements. Some recent activities include: 1) The DHEC performance management system has been evaluated and is being redesigned based on this evaluation to be more user-friendly. 2) The SC WIC program has begun to share consenting clients' contact information with the SC Pregnancy Risk Assessment Monitoring System (PRAMS) through an automated matching of records within the Client Automated Record and Encounter System (CARES). This match does not require PRAMS staff to access the CARES system. 3) The SC Community Assessment Network (SCAN) has been updated with the most current data making data collected by DHEC publicly available. 4) The SC Birth Data Exchange Engine (BEE) has been updated to allow for more efficient data collection and management for the SC Birth Defects and Newborn Screening. 5) Work has been done to begin the development of a module within the BEE system for the collection and management of Fetal and Infant Mortality Review data. 6) MCH staff have continued to foster good working relationships with SC Office of Research and Statistics (ORS) staff. ORS is the repository for Medicaid, hospital discharge, State Health Plan, and Department of Education data, among data from other sources. //2013//

G. Technical Assistance

MCH has identified three key areas of technical assistance 1) Program planning and formal evaluation; 2) expanding existing staffs knowledge, skills, and abilities related to data analysis and program evaluation; 3) effective policy and advocacy for MCH populations.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11406437	11572823	11366578		11298304	
2. Unobligated Balance *(Line2, Form 2)*	199538	162154	612543		326540	
3. State Funds *(Line3, Form 2)*	11181420	10476784	9052174		8139403	
4. Local MCH Funds *(Line4, Form 2)*	6514290	5788842	5833678		5877399	
5. Other Funds *(Line5, Form 2)*	32774592	27350140	34167550		27387354	
6. Program Income *(Line6, Form 2)*	16133189	8603653	13860222		13999073	
7. Subtotal	78209466	63954396	74892745		67028073	
8. Other Federal Funds *(Line10, Form 2)*	109735712	107714224	102322902		105474634	
9. Total *(Line11, Form 2)*	187945178	171668620	177215647		172502707	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	811259	929968	870738		974663	
b. Infants < 1 year old	2770267	2694163	2970614		2823645	

c. Children 1 to 22 years old	4687461	3746046	5380683		5315309	
d. Children with Special Healthcare Needs	11320863	10235383	13846615		10727300	
e. Others	56886603	44860152	50278696		45626925	
f. Administration	1733013	1488684	1545399		1560231	
g. SUBTOTAL	78209466	63954396	74892745		67028073	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	107922		104550		126173	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	101862845		93763842		95697527	
h. AIDS	0		0		0	
i. CDC	377857		356670		417123	
j. Education	0		0		105483	
k. Home Visiting	0		0		0	
k. Other						
Children's Trust	0		0		53164	
Family Planning	6941795		6911902		6716459	
Infant Health PRAMS	0		180099		204362	
Newborn Hearing	0		0		455705	
Nurse Fam Ptnership	0		0		110164	
Pers Responsibility	0		334799		891386	
Rape Prevention	0		0		485605	
Sexual Assault	0		198108		211483	
Nurse Fam Ptnrshp	109769		212759		0	
Univ Nwbrn Hearing	211668		260173		0	
EHDI Tracking	123856		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	11108549	9337689	11193124		9786463	
II. Enabling Services	65869599	54120457	62934664		56721511	
III. Population-Based Services	702827	273935	369338		287100	
IV. Infrastructure	528491	222315	395619		232999	

Building Services						
V. Federal-State Title V Block Grant Partnership Total	78209466	63954396	74892745		67028073	

A. Expenditures

Variability in budget reporting from year to year is becoming more evident. The primary source of the variability stems from ongoing challenges in defining and measuring Title V program activities and individuals served. There have been significant internal changes in defining and reporting the number of individuals served under Title V (Form 7). In previous years we have been able to define and report these numbers from well-established internal client databases. However, there has been a substantial movement away from the direct services, which provided the basis on which these numbers were predicated. Defining the Title V population in the context of population based/infrastructure building services has been a challenge. For the most part, available program information regarding WIC participation, and program service estimates for CSHCN have been used to establish the populations served by Title V. However, this does not capture the full essence of Title V program activities.

The ongoing variability in defining the Title V population served also impacts budgeting information provided. Reported expenditures for pregnant women, infants, children, CSHCN, others, and administration are only as stable as the Title V population served information contained in Form 7. Variability in defining Title V population served creates variability in budget reporting from year to year. Moreover, existing cost-accounting methods and data systems are designed to capture program activities and have difficulty capturing effort towards population based/infrastructure building services. This is a potential source of bias in budget reporting and could explain the disparity related to expenditures on direct/enabling services compared to population based/infrastructure building services.

Over the next year special attention will be given to establishing a reasonable, reliable definition related to the number of individuals served under Title V with a clear, consistent data source. In addition, efforts will be made to examine the existing cost-accounting system to determine the extent to which population based/infrastructure building efforts and program activities can be more clearly captured. As HRSA Title V program expectations continue to shift towards population based/infrastructure building activities, clearer definitions of acceptable Title V population definitions is warranted.

B. Budget

As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care. As noted in Form 2, the 41% of the federal allocation was spent on preventive and primary care services for children, 33.2% on services for children with special health care needs, and 9% of Title V administrative cost. State and local funds include several programs and initiatives directly and indirectly related to MCH populations not directly funded under Title V. In some instances local services are able to direct program revenue which provides additional funding to support ongoing program operations.

/2012/ As noted in Form 2, 56.5% of the federal allocation is on preventive and primary care services for children, 33.5% on services for CSHCN, and 10% on Title V administrative cost. //2012//

/2013/ As noted in Form 2, 47% of the federal allocation is for preventive and primary care

services for children, 31% for services for CSHCN, and 9% for Title V administrative cost. //2013//

The Agency uses the Personnel Cost Accounting System (PCAS) to document personnel expenses. Annually MCH staff review PCAS codes and realign with the levels of the MCH pyramid. As noted in the previous section, PCAS has difficulty capturing program activities related to population based/infrastructure building activities. The Bureau and the Agency will continue to work toward determining the best means of capturing program activities and effort down the MCH pyramid as program focus continues to shift.

The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466. FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. We requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500. The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2011, state appropriations for organizational units under the direction of the state Maternal and Child Health Director are expected to be $11,181,420. We also identify Health Services Central Office state funded personnel costs in the amount of $419,923, as these staff are in MCH Divisions. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $155,377.

/2012/ For FY 2012, state appropriations for organizational units under the direction of the state MCH Director are expected to be $9,052,174. We also identify Health Services Central Office state funded personnel costs in the amount of $384,530, as these state funded staff are in the MCH Bureau. Additionally, we identify county funded staff in the amount of $2,019,282. //2012//

/2013/ For FY 2013, state appropriations for organizational units under the direction of the state MCH Director are expected to be $8,139,403. The $912,771 reduction from FY 2012 is due to the transfer of South Carolina's Early Intervention for Infants and Toddlers with Disabilities to another state agency. We also identify Health Services Central Office state funded personnel costs in the amount of $484,156 in the MCH Bureau. Additionally, we identify county funded staff in the amount of $2,822,407 to meet our maintenance of effort requirement. //2013//

Match: Title V matching requirement for the FY 2011 grant award of $11,406,437 is $8,554,828. We identify $8,554,828 of the state allocation in the Women and Children's Services, Children with Special Health Care Needs, and Research and Planning organizations as match.

/2012/ Match: Title V matching requirement for the FY 2012 grant award of $11,366,578 is $8,522,447. We identify $8,522,447 of the state allocation in the Maternal and Child Health organizational units as match. //2012//

/2013/ Match: Title V matching requirement for the FY 2012 grant award of $11,298,304 is $8,474,152. We identify $8,139,403 of the state allocation in the Maternal and Child Health organizational units as match. We also identify Health Services Central Office state funded personnel costs in the amount of $334,749 in the MCH Bureau.//2013//

Fiscal Management Procedures: The Bureau of Financial Management procedures can be provided upon request.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.